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A NEW YEAR'S MESSAGE

Traditionally, the dawn of a new year is supposed to be a time for good resolutions. Fortunately or unfortunately, the psychological effect of anything so formidable is to develop an equally strong temptation to show one's independence by breaking those same resolutions. So let us not, at least in relation to our work, run the risk of barriers to accomplishment through solemn promises to ourselves and others. There is, however, a certain exhilaration in stock-taking and in the recognition of goals, and the New Year—especially this new year—may be an appropriate moment to ask ourselves some questions:

What measures have we to estimate how far the work for which we are responsible is progressing toward the goals of the public health nursing program?

In what ways and how often do we apply the available measuring rods to our own activities?

To what extent are we keeping in touch with the scientific discoveries and trends in the whole health field and in allied fields?

Is our program sufficiently flexible to allow the constant application of this newer knowledge to the scope and details of our own task?

Do we believe in what we are doing with a spirit which brings with it the imagination and courage to see and face what we are *not* doing—and go to it!

The accomplishments of any movement depend in large part upon workers who are constantly inquiring, questioning and studying; who are unafraid of change and adaptations; who have a sense of direction; and above all, who believe in and enjoy what they are doing—at New Year's and all through the year.

Happy New Year to you!

KATHARINE TUCKER

Meeting the Economic Emergency

IN May 1931 the National Organization for Public Health Nursing took a sampling of salary changes in 102 public health nursing agencies, and reported (see THE PUBLIC HEALTH NURSE, May 1931) that in 75 associations there was no reduction in salaries and the usual increases were provided for; fifteen associations reported no increase in salaries, and 5 that if business conditions improved, increases would be given, otherwise not. One association reported two weeks of additional vacation allotted to each nurse without pay. This was the only change in vacations reported by any agency.

In August, a questionnaire sent to a representative number of agencies showed a more serious state of affairs in that many agencies reported a large increase in work, with decreased earnings, and uncertain financial outlook for 1932.

However, it was not until the budgets for 1932 were planned that it became evident generally that some cuts in expenses would have to be considered in both official and non-official agencies. It was then that the N.O.P.H.N. became deluged with requests for advice: Shall we cut salaries? How? Shall we draw on invested funds or cut program? Is it better to drop staff nurses or cut salaries? What are other associations doing?

The Executive Committee of the Board of Directors immediately authorized the appointment of a committee (announced last month) to consider the effect of the present economic situation on public health nursing and to advise the N.O.P.H.N. in whatever action or leadership it assumed in relation to the emergency. The committee, to be known as the Committee on the Economic Emergency, of which Miss Elizabeth Folckemer, director of the Visiting Nurse Association of Cleveland, is chairman, held its first meeting in November and its recommendations to the N.O.P.H.N. follow:

To gather facts at once from official, non-official, urban, and rural public health nursing agencies as to the changes in administration, income, expenses, program, relationship to other agencies, and other factors which are due to the economic emergency.

Acting on this recommendation, questionnaires are being prepared to secure a sampling of conditions all over the country, and it is hoped when these questionnaires are returned that the N.O.P.H.N. will then be in a strategic position to answer the question: What are the other agencies doing? From these facts, also, the committee hopes to be able to judge how satisfactory adjustments may be made to certain of the changes growing out of the depression. Its members are convinced that the situation will teach valuable lessons which may be applicable to more prosperous times, just as they are aware of emergency adjustments which it would be very unfortunate to perpetuate.

To publish in the January 1932 number of PUBLIC HEALTH NURSING a progress report of the committee's work, at the same time suggesting certain safeguards to standards and policies which meet with the approval of the committee and may be of help to local groups.

These suggestions follow:

1. That before cuts in program, service, or salaries are effected, it is recommended that every agency scrutinize its local program and its function in relation to other social and health agencies, with a view of discovering any duplication of service or overlapping of function, or possible combination of forces.

2. That careful consideration be given to the essential reason for and benefit from the services now offered.

3. That all possible economies in

administration be practiced, for example: in rent, supplies, transportation, reduction of absentee visits, etc.

4. That before cuts in program are made, the effect of such reduction in service be considered in relation to (a) the community situation and need, (b) the other agencies dependent on, or connected with the program, (c) the responsibility of the public health nursing agency for leadership in any particular field, (d) the stage of development of the service to be cut.

5. That all possible means for retaining any service be considered, such as asking for support from tax funds if any service concerns work for which the official group might legitimately pay.

6. That agencies review federal, state, county and local legislation to find out whether or not recent changes have made possible the delegation of responsibility to official funds—for example, care of dependent, crippled children.

7. That the point be stressed and utilized that a citizen's group has an added responsibility at this time to support the service, or to see that the official agencies are bearing their full share by pointing out that free service to citizens unable to pay for it is a just lien on tax monies.

8. That it would seem wise to arrange that the services most easily taken over by other agencies would be the first to be eliminated.

9. That very serious consideration be given to using invested funds, which after all are intended for emergencies, before too radical a change in program, or cutting in service, is undertaken.

That before invested funds, or the principal of an agency, is drawn upon, the business advisory committee, or business men and bankers in the community, be consulted both as to advisability of drawing on capital and as to the method. It is of course recognized that certain investment securities ought not to be sacrificed in this period of depression.

SALARY CUTS

The committee believes that the question of cutting salaries is one on which the N.O.P.H.N. can offer little advice without full knowledge of local conditions. Certain general principles would seem to be applicable, however, in most situations. It was agreed that in communities where all workers, industrial, business and social, have accepted cuts in salaries, it would be impossible and unwise to recommend that the salaries of public health nurses be not cut. It was felt, however, that before cuts are made, the board might well review the salary scale in relation to salaries being paid in communities of like size, in relation to the salary study made by the N.O.P.H.N. in 1930 * and in relation to local standards of living.

When salary cuts are found necessary, it is recommended that the salary schedule be maintained if possible. This might be through staff contributions to the agency in time or money. A cut in salary could be either a graded cut according to salary received, or a cut made on all salaries after a certain fixed amount was exempted. For example, $1,200 exemption and a 10 per cent cut on the balance of all salaries, *on the basis of regular salary increases,* would serve as a graded cut which would still recognize the original salary scale.

The committee agreed in stressing the point that volunteers should be used as generously as possible to meet the increased need, in positions for which the budget makes no provision and for which volunteers may be trained, not, however, to replace employed workers as a saving per se.

QUESTION OF RELIEF

The committee recognized that the present situation is placing some agencies in a position where it is necessary to carry on a certain amount of

* See THE PUBLIC HEALTH NURSE, May, 1930.

relief-giving over and above the usual individual medical relief. This is particularly true in communities where the family societies are swamped with case work and relief and where a milk or cod liver oil fund has been offered to the public health nursing agency. The committee recommends that in all cases where relief other than the accepted individual medical relief is to be administered by public health nursing agencies, the following steps be taken to safeguard the temporary procedure:

1. If it is not possible or not wise to deflect the special funds for relief to a relief-giving agency, it is recommended that the relief procedure carried on by the public health nursing agency be regarded as only one phase of the whole community plan of meeting the present situation and that the project be presented to and approved by the appropriate committee of the council of social agencies, if there is one.

2. If there is no council of social agencies, it is suggested that the public health nursing agency consult the other relief-giving agencies as to methods of administration, procedure, etc.; all cases to whom relief is given be cleared first through the social service exchange, and if known to another agency, that agency be consulted in regard to the relief plan, and notified when relief is discontinued.

3. If relief is given in any large measure, that a social worker be added to the nursing staff as consultant, either on full or part time,—this worker might be loaned by the family welfare society—and a social service committee of the board be appointed with the family society represented.

4. In rural communities where social workers are not available, it is advisable for the nurse to form a social service committee and insofar as possible, delegate the actual relief-giving to this committee.

5. In all public health nursing agencies, the giving of material relief over and above the accepted individual medical relief, be regarded as an emergent, temporary measure.

ELIZABETH FOLCKEMER
Chairman, N.O.P.H.N. Committee on the Economic Emergency

Combating Unemployment Malnutrition

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THE present economic emergency brings renewed interest in the problem of malnourished children. An increase in the number of inquiries coming to the National Organization for Public Health Nursing and the American Child Health Association during the past few weeks concerning methods for easy and rapid selection of undernourished children suggests the probability that there is an urgent demand for special health services to protect children from malnutrition as a result of unemployment. This interest is a proper one, but an earnest desire for immediate service should not lead us away from the real problem now confronting us.

Recently a changed point of view has been attained through research which shows clearly the fallacy of trying to select undernourished children by the simple device of determining underweight for height. As the height-weight tables are more useful for determining body build than nutritional status, it is recommended that they be discarded as a ready means of screening out the children in need of school lunches or nutrition clinic care.

The widespread use of the height-weight tables as a means of selecting malnourished children has developed in some places extensive administrative machinery relying upon a fallacious criterion of nutritional condition. Our concern for protecting malnourished children should not lead us into unwise selections of children for special services. If we are to serve the children most in need, we must make valid and reliable selections. The nurse who spends her time finding children underweight according to a so-called normal weight zone is directing her efforts away from the families who need advice on how to spend a slender budget to obtain a maximum of nutritional value through a wise selection of food.

If malnutrition as a result of the depression is to be combated, we should prevent it rather than attempt to cure it. Prevention for unemployed families requires finding the underfed children rather than the children whose growth has been affected. To wait for evidence of retarded growth is like waiting for rachitic deformities to develop before administering Vitamin D.

Of course neither the nurse nor the teacher can truly discover the underfed child by asking the children in the schoolroom to raise their hands if they have had no breakfast. On the other hand, the teacher with a well organized health education program can find out fairly accurately the variety of food consumed by her class for a week and from such a record determine the children who are obviously suffering from a shortage of milk, fruit or vegetables or other serious dietary insufficiency. The nurse can contribute to this service by suggesting such a study to the teacher and assisting her in selecting the most needy children from the records of food consumption.

Underfeeding and malnutrition are not merely problems of insufficient food. The restricted budget usually means restriction on foods needed for growth and nutrition. Excellent advice for teachers, parents and relief agencies as to food selection for a maximum of nutrition at a minimum of cost will be found in pamphlets published by the American Child Health Association, "Emergency Nutrition" by Henry C. Sherman, and "Food at Low Cost" by Lucy H. Gillett.*

* American Child Health Association, 450 Seventh Avenue, New York City. Ten to 25 copies, $.01 each; special prices on quantity orders. Dr. Sherman's pamphlet: Single copies, $.03; 10 to 24 copies, $.02; special prices on quantity orders.

RESOLUTIONS ON UNEMPLOYMENT RELIEF

The committee on administration of relief has sent to the President's Organization on Unemployment Relief of which Walter S. Gifford is director, a set of resolutions, of which the following relate most closely to the work of public health nursing agencies:

An effective program of unemployment relief is dependent upon the closest coördination of all public and private agencies in a given locality.

A unified employment system and a social service exchange, qualified personnel in charge of administration of relief, and an approved accounting system will guarantee the best results to those in need and to the community as a whole, and will greatly enhance the confidence of the community in its own relief program.

Responsibility for adequate local funds for relief is primarily a joint obligation of local public authorities and private agencies and the degree of responsibility of each of the two groups will vary in different localities and under different conditions. Administration of relief funds will require close coöperation of both groups.

Where qualified public or private agencies experienced in the handling of relief already exist in any community, unemployment relief funds should, wherever possible, be administered by them rather than by new and untried agencies specially organized for that purpose. Such a policy is less expensive and assures more adequate handling of the problem and less confusion of effort.

The established services to the sick and needy, to the children and to young people; provisions for the constructive use of increased leisure, and the whole program of social welfare are more necessary under present conditions than ever in the life of communities. The maintenance of morale, confidence, character, and physical well-being depends on the continuance of such services.

It is imperative in the emergency that an adequate community program of such services be maintained.

We urge an endeavor to preserve the independence and self-respect of the unemployed through avoidance of public bread lines, soup kitchens, and public distributions of food and clothing. Where such projects are conducted by commercial or other organizations primarily or indirectly as a means of self-advertising, they are particularly objectionable and should be condemned by public opinion.

Relief to families should, wherever possible, be suited to their individual needs and given in their own homes. Unemployed men with special problems should receive personal attention. Where feeding stations or other types of mass care become necessary, the facilities should be such as to insure as much privacy as possible.

AN INDIAN HEALTH HONOR ROLL

Definite goals of health attainment for the child, toward which the parent, too, must strive, with the points stressed on which the family must coöperate for full accomplishment, will help to fix attention on the child's needs and lead to action for his welfare. Undoubtedly there is more difficulty in thus reaching families of foreign speech and alien mode of life, and success in moving a group of non-English speaking parents to interest and action deserves special mention.

Mrs. Elizabeth Hathaway, public health nurse on the Crow Indian Reservation in Big Horn County, Montana, has set up a Health Roll of Honor for the Indians. These are its ten points:

Normal weight.	Normal eyesight.
No bad tonsils.	No eye disease.
No adenoids.	No skin disease.
No permanent teeth decayed.	No head lice.
Normal hearing.	No other apparent defects.

The conditions listed last relate to defects most often found in Indian homes, where the eye disease, trachoma, skin conditions such as scabies, impetigo and other communicable diseases, and vermin on the head and body spread through whole families in their crowded living conditions.

The "honors" awarded are adapted to the circumstances of these Indian children. In another county, with English speaking families, the names of those who had made the Roll of Honor were printed in the local newspapers by the school nurse, and this publicity was a source of pride to both home and school. But the Indians had no local paper in their language, and few of them would see the list of honors if published by the county press. The problem was solved by the nurse's offer to each child, who achieved the ten points, to have his picture taken with her camera.

Within one year after the plan was begun, over sixty children had gained the coveted "honors," and at the Community Fair held by the Crow Indians, a poster setting forth the Roll of Honor, bordered with the photographs of all the successful children held a place of note among the exhibits.—*From a letter from Dr. MaBelle True, Former Director of Child Welfare for Montana.*

The Nurse in the County Health Unit

Foreword: Several months ago on recommendation of its Advisory Committee, the National Organization for Public Health Nursing invited the State and Provincial Health Officers to join with it in appointing a committee to study the relation of the public health nurse in a county health unit to her health officer and to the State health officer and State director of public health nursing. The following report submitted by this joint committee has been approved by the Conference of State and Provincial Health Authorities of North America and by the Executive Committee of the National Organization for Public Health Nursing.

County Health Units, the generally accepted ideal for the organization of county health work, are on the increase and eventually, it is hoped, will prevail in all counties. It is axiomatic that public health nursing is an essential service in these Units, so essential in fact that a rather high proportion of the budget is used for this purpose.

This being true, and also the fact that the total budget of the average Unit is the minimum for effective work, it becomes imperative to plan and to manage the nursing service in such a way as to get the greatest possible returns from it. The selection of the nurse, the mapping of her program, the arrangement of her work, the use of her particular abilities, the mobilizing of volunteers to help her, the provision of the essential tools for her work—these and other like matters take on importance in the effort to make the nursing service produce returns. Perhaps the most important problem of all is to work out a place for her in the scheme of the Unit which will insure the most effective dovetailing of her work with that of the Unit as a whole, and at the same time allow enough initiative and responsibility to attract a high-grade public health nurse to the Unit and to keep her on her mettle.

This report attempts to set forth certain organization and administrative procedures which it is believed should secure the maximum results for the Unit from the nursing service. It concerns only the nursing service which is maintained entirely by the Unit, and not a service which may be maintained jointly with some other agency.

THE SPIRIT OF THE UNIT IS THE KEYNOTE

At the outset it is agreed that the spirit is more important than the mechanism. A good plan often goes wrong where morale is lacking, and even a bad plan has a good chance of success where enthusiasm, confidence and goodwill are present. This is not intended, however, as an argument in favor of bad plans.

This spirit is most likely to prevail where the health officer of the Unit looks upon his staff as a group of experts working with as well as under him for a common cause, and where the staff are capable of thinking in terms of the whole and of sinking personal or professional pride, in pride of the Unit, and in terms of the public good and public welfare regardless of individual opinions, traditions or special interests.

That an ideal relationship between leader and staff is difficult, and demands broad qualities, we admit. It is relatively easy to be the boss and to be bossed. It is far more of a test to be the leader of a group of free minds, exercising authority without dictatorship and encouraging individual responsibility and initiative without losing unity of purpose and action. Likewise, it is a difficult challenge to the staff member to accept responsibility and to use his initiative without getting out of step.

To sum up, we believe the work of the County Health Unit must be a harmonious whole in spirit and in fact, and that to achieve this there must be central authority, the health officer, but that the Unit is likely to have

greater vitality and richer development if the health officer will delegate to his staff as much responsibility and initiative as possible within the limits of the policies and program laid down for the Unit as a whole.

HOW THIS MAY BE ACCOMPLISHED

It may be useful to outline what is meant by this general statement. The theory of a partnership, the health officer being in command and the staff experts being of equal status with each other, would mean, we assume, that important matters affecting the work of the Unit as a whole, such as the annual choice of objectives, the arrangement of the work to achieve these objectives, the policies governing the work, even the make-up of the budget will be discussed with the staff, the health officer of course having final authority, but in so far as possible giving the staff opportunity to make suggestions before he comes to a decision.

Having decided upon objectives, the staff should be required by the health officer to present him with plans for the utilization of their respective services to the best advantage in gaining these objectives. This would force the individual staff member to think and to weigh values; it would also give him a chance to use all the inventive talent he or she had, as well as his more intimate knowledge of procedures in his own field. It would then be necessary for the health officer to coördinate and unify these individual service plans, making such changes as he might think advisable, after discussion with the group as a whole or individually.

There are numerous ways in which the health officer may keep his staff "on their toes." We suggest only a few, such as including them in discussions with others on matters touching their particular fields; having them meet distinguished visitors; allowing them to speak for their particular branch of the work; encouraging them to write about it; training them to prepare monthly reports and to develop the habit of analysis, and in all ways treating them as partners who have a stake in the success of the Unit.

On the other hand, each staff member may contribute his share to the enthusiasm of the Unit by learning to think in terms of the Unit and not merely his own specialty; to give and take; to adjust his methods to the common methods; to put the work that is to be done ahead of professional privilege. He must accept decisions which may not always seem to him for the best, with a high sense of loyalty. Difference of opinion well under control may often be wholesome, but where there is such incompatibility as to affect his loyalty to the Unit, his resignation becomes necessary as a matter of self-respect.

We have dealt here in terms of the whole staff because we have no desire to single out the nurse for peculiar honor or individual treatment, and because we believe the methods which will arouse her to her best efforts will produce the same result from the other members of the staff.

Among the members of the staff themselves, it is obvious that there must be a relationship based on interest, collaboration, respect and willingness to share and share alike.

FUNCTIONS OF THE NURSE

We believe the particular and unique value of the nurse lies in her ability to individualize the work of the Unit. We mean by this that the public health nurse provides the best instrument for carrying health information to the individual and helping him to adapt his circumstances and habits to healthful practices. There are only a few health measures that can be taken for the protection of the community without the active coöperation of the individual—the installation of a sewage system and water system being almost the only ones. Some others, such as the requirement of standards of cleanliness in dairies, markets, bakeries, usually do not require coöperation other than that of the individual workers involved. Practically all other efforts to protect or improve health depend for

results on the understanding and voluntary coöperation of the individual. He can be instructed in the general principles of hygiene en masse through pamphlets, lectures, the radio and the like, but usually more than this is needed. To get the man in the street to change his habits, one must translate generalizations into terms of his own situation and needs. Someone must sit down with him, in his own home if possible, first to convince him that good health habits have concrete measurable value in his own life, and then to advise him in detail about the hygiene of his own individual environment and behavior. It is in these repeated individual consultations, particularly in the homes of the people, that the nurse makes her peculiar contribution and does her most valuable work. Without such personal attention, help and stimulation, many people either are not sufficiently impressed to take heed of mass health instruction, or put off through inertia doing anything about applying these ideas to their own lives. Without persistent follow-up, much health propaganda is ineffective.

This being true, we believe that best results will be obtained from the rather large proportion of the budget which goes into nursing service, if the nursing program allows for a considerable amount of work in the individual homes.

It is not the purpose of this paper to lay down a specific program for the nursing service in Health Units. Manifestly this would be absurd, as the particular objectives to be attained differ from Unit to Unit and from State to State. It is perhaps sufficient to quote the statement of fundamental nursing functions given in *Community Health Organization* published by the American Public Health Association:

1. The home visitation of cases of acute communicable disease for the instruction of attendants in the technic of isolation and concurrent disinfection, for the taking of cultures and preliminary examination of contacts, and for the dissemination of knowledge in regard to the value of vaccine and serum therapy.

2. The assistance of physicians at tuberculosis clinics, and home visitation for bringing contacts and suspicious cases to the clinics, for instruction of patients in home care and for the following up of arrested cases.

3. The assistance of physicians at venereal disease clinics, and home visitation in special cases where such visitation may be advisable.

4. The assistance of physicians at prenatal clinics and infant welfare clinics, and home visitation for the instruction of mothers and expectant mothers in the hygiene of maternity and infancy.

5. The assistance of physicians at preschool clinics in the examination of children of this age period, and home visitation to secure needed treatments and to instruct mothers in the hygiene of childhood and the importance of proper habit formation.

6. The assistance of school physicians in the examination and supervision of school children, and home visitation to secure needed treatment and to instruct mothers and children in the hygiene of childhood.

These are generally accepted as the primary functions of the public health nurse working under official agencies. To them we would add a seventh—the promotion of group education through classes in child care or in personal, home and community hygiene and care of the sick (such as the course in Home Hygiene and Care of the Sick of the Red Cross), through informal conferences of mothers and of teachers; through talks to groups and through assistance with all schemes for arousing public interest. Nursing care of the sick, it will be noted, is not included in this description of functions. Although this service is needed in every community and county to complete the public health nursing program, official agencies having limited personnel have felt it more important to concentrate on directly preventive and educational work except in some instances where visits for demonstration purposes are made.

OBSERVATIONS ON THE MANAGEMENT OF THE SERVICE

On the basis of this conception of the public health nurse's functions, we shall attempt a few observations with respect to the management of her work which may be of general value. Generally speaking, it would seem:

That field work in the homes should receive as much emphasis as work in the schools, the clinics, in classes and group conferences, or in consultation hours at the office;

That her work in so far as possible should consist of expert service and that mechanical work, such as running errands, distributing supplies, escorting cases to hospital or clinic (who might as well be taken by the family or by a lay person) acting as chauffeur for other workers, and the like, should be kept to a minimum by the use of volunteers or lower priced workers;

That the use of volunteers as assistants to the nurse for many non-technical duties, such as helping at clinics, is to be encouraged, both because this releases the nurse for more expert service and because it gives the Unit valuable allies;

That clinics which are not followed by field work in the home are of little value;

That the success of the health education program in the schools depends largely on the extent to which the teachers are encouraged to supervise the health of the children in school and to be interested in good health habits; that while it probably will be necessary for the nurse to help the teachers learn how to do their part, she should devote her efforts largely to educating the parents in the home;

That while rigid adherence to a set program is seldom wise, it is usually better for the nurse to concentrate her attention on a few definite undertakings carefully planned for the year in connection with the objectives of the Unit, than to scatter her efforts over a diffused and vague program, likely to result in frittering away her time on inconsequential matters;

That the principle of generalization as against specialization is generally accepted as the only feasible one in a County Unit with limited personnel.

PUBLIC RELATIONS

While responsibility for official transactions between the Unit and other governmental bodies, as the school board or county commissioners, should of course rest with the health officer, the nurse should be allowed ready access to these officials, to court and welfare officials and to the teachers, on detail matters arising in the routine application of policies already laid down. This is recommended in order to relieve the health officer of unnecessary detail, to facilitate the work and to increase the usefulness of the nursing service. While an enthusiastic nurse may sometimes overstep her authority, a few mistakes are less serious than the ineffectiveness of a worker who is dependent on the health officer for instructions in every action other than strictly routine. An intelligent nurse working with a health officer who is a good teacher should learn where to draw the line. It is assumed that the health officer will be responsible for the maintenance of a sympathetic and intelligent relationship with the medical profession. However, the importance of this relationship should be impressed on every member of the Unit. Especially is it necessary that the nurse keep in close touch with the physicians for their information and for her guidance. This detailed coöperation should of course be in accordance with the general principles laid down for the Unit as a whole by the health officer.

It is also in the interest of the Unit that the nurse should be encouraged to maintain friendly relations with the unofficial agencies which are in a position to aid and supplement the work of the Unit, such as the local Chapter of the Red Cross, the local tuberculosis society, the Parent-Teacher Association, the women's clubs, Rotary Club, and the like. Obviously her coöperation with these agencies should be with the knowledge and consent of the health officer, and in accordance with the general policies laid down by the Unit.

QUALIFICATIONS

It is apparent from the foregoing that the Health Unit requires a high-grade public health nurse. She must be a woman of intelligence, ability, gumption and sympathy, and should be free from temperamental handicaps. In addition, she must know what she is about—that is, she must have a knowledge of public health work and particularly of public health nursing, in order to plan and manage her own duties to get maximum results.

One sometimes hears a health officer say he would rather take a green nurse and train her himself to do the things he wants her to do than to employ a

qualified public health nurse. He fears that the latter might have too independent a disposition and too little patience. That an occasional Unit nurse has been too individualistic or aggressive we do not doubt, since nurses, like health officers and the rest of mankind, are subject to human failings. We do not believe this constitutes a valid argument, however, for condemning all qualified nurses, and for crippling the work of the Unit with an incompetent one, for the health officer has little time to teach the green nurse anything but routine tasks.

Too much of the limited budget of the Unit goes into the nursing service to waste any of it on ineffective or amateurish work. It should be spent for expert service alone, and such service can only be expected, with rare exceptions, from a nurse who "knows her stuff" and who has been trained to use her head.

We think it is generally accepted, with the exception of a few health officers, that the better qualified the nurse is by education and experience, providing she has that *sine qua non,* a pleasant and straightforward personality, the greater her potential contribution to the work of the Unit. Whether this potential contribution becomes an actual contribution depends more than anything else, we believe, on the spirit which the health officer infuses into his staff.

Since the supply of nurses of the type just described is limited, the good offices of the State Department of Health should be used freely in seeking candidates and in determining whether they are qualified professionally and personally for the work.*

SUPERVISION

The principle of supervision by one's own profession is a basic principle in sound organization—supervision, however, not in the old-fashioned sense of the term, but in the sense of homely advice, encouragement, stimulation, help from one who has had greater advantages or wider experience to one who has had less.

The director of nursing in the State Department of Health presumably has better judgment, more experience and a wider point of view than the nurse in the Unit, and should therefore be able to help her.

A State nurse is responsible to the State health officer; a Unit nurse to the Unit health officer, and the Unit health officer to the State health officer. This we believe to be sound organization. How then shall the connection between a Unit nurse and a State nurse be made? A Unit nurse we believe should be allowed to consult and a State nurse to advise on all matters involving technical problems. We can find no good reason for limiting the subjects which may be discussed. An arbitrary prohibition seems to us a confession of weakness. The necessary safeguard, we believe, lies not in limitation, but in expecting and demanding fair play. Any advice given by a State nurse, it goes without saying, should be given in collaboration with the State and Unit health officers, and should later be made a matter of record in a written report to the State health officer. We will go further and say that the State nurse should not advise the Unit nurse with regard to any policies affecting the Unit without the approval of the State health officer. This procedure should prevent crossed wires and misunderstanding, and preserve the central integrity of the State Department's relation with the Unit. However, the success of this liberal policy depends more than anything else upon the spirit in which it is discharged. If a State nurse sees only public health nursing, she may make trouble in the Units by siding with the Unit nurse in all her difficulties and even magnifying them. The trouble here is not with the procedure, but with the State nurse, whose intentions may be of the best, but who obviously

* *Editorial Note:* **The Joint Vocational Service, 132 East 22nd Street, New York, N. Y., sponsored by the National Organization for Public Health Nursing, is always ready to assist in finding suitable nurse candidates.**

does not understand good organization and team play. We would consider such a nurse so serious a liability to the State Department as to require elimination.

On the other hand, a State nurse who is honestly interested in the success of the Units will be anxious to help in every way in adjusting friction should there be any, and to aid her own chief, the State health officer, as well as the Unit health officer and Unit nurse, to get the best results from the nursing service. She will understand that the loyalty of the local nurse to the Unit is best advanced if she, a State nurse, pursues a completely open and sympathetic but unprejudiced course of action. She will understand furthermore, that matters affecting fundamental organization and policy should be left to the State health officer to adjust. A State nurse who has this spirit, and consequently has the support and confidence of the State and Unit health officer, as well as the nurses, is a tremendous asset to any State.

Incidentally we believe that the Unit nurse should be allowed to correspond with the State nurse, such correspondence to be filed in the open files of the Unit and State respectively. As a matter of principle, any problem referred to in this correspondence should first have been discussed with the health officer. Where the right spirit prevails and where there is intelligent understanding of sound organization, this procedure should not endanger the principle of central authority and unified control.

Moreover, we believe that the State nurse should be expected to initiate educational schemes of many kinds designed to aid the Unit nurses, such as outlines, reading lists, monthly bulletins and news notes—all of these, of course, with the approval of the State health officer.

Summing up all of this in a few words, the committee recommends consideration of the following points as containing the essence of success in getting maximum results from the nursing service:

1. Recognition that the spirit of the Unit is more important than its mechanism.

2. Development of the Unit so that the health officer, as the leader in authority, confers a broad measure of responsibility on his associates, and in return expects their loyalty to the central objective and spirit of the Unit.

3. Appointment of nursing personnel of the highest grade of expertness obtainable, and also capable of team work and group loyalty.

4. Annual formulation of a practical program and plan for the nursing service drawn up by the nurse and the health officer together, placing emphasis on personal contacts in the homes and giving the nurse a clear idea of the relation of her work to the program of the Unit as a whole.

5. Opportunity for the nurse to establish active and cordial relations with other officials and voluntary agencies, as necessary, in connection with her work, but always in line with the policy of the Unit.

6. Opportunity for the nurse to obtain practical aid and advice from the State nurse on technical matters affecting her work.

ELIZABETH FOX, *Chairman*
DR. E. L. BISHOP
ADA TAYLOR GRAHAM
DR. WILLIAM KING
MRS. CHARLES WEAVER
DR. ENNION WILLIAMS *

* Deceased.

Team Work Between the Nurse and Social Worker*

By MARGARET F. BYINGTON
New York School of Social Work, New York City

TEAM work may be considered to involve three elements:

1. A common purpose recognized as being such.
2. The utilization of the experience and ability of each member of the team, with a recognition of the real value resulting from such variety of experience.
3. A good technique of collaboration.

Let us consider as a basis for discussion the common purposes and interests of the public health nurse and social worker; the varieties of skill and knowledge which the two groups contribute toward achieving a common end; and the procedures through which effective collaboration may be secured.

OUR COMMON PURPOSE

We may summarize our common purpose as being a better life for those individuals and families known to us, and to that end, the development of more adequate community resources. Such general purpose will be modified, of course, in accordance with the special interests of each worker and their points of attack on problems presented. We may, for instance, find quite genuine differences in the points of view of workers in the medical and family fields. They may set different values on immediate social objectives, such as health versus economic independence. Nevertheless these differences may be resolved in terms of the larger purpose if we have mutual confidence in the aims and the technique of the other workers, and a willingness to use our own efforts to further the purpose of their organization as well as our own.

We recognize that a better life for any individual is a complex of many elements, that health and work opportunities have a close inter-relationship; that an emotionally satisfactory family life is based in part on adequate financial resources and on health; that children who grow up in a home lacking normal disciplinary values may be deprived alike of health, character development and future economic stability. You cannot set off these elements in family life into separate compartments, one worker fostering health and the other emphasizing the importance of economic conditions. We must face the question as to how our ultimate goal may be achieved through a relating of these various immediate objectives.

KNOWLEDGE AND SKILL

If we grant the ultimate unity of our goal, we come to the question in practice, what are the various types of information and skill which the nurse and the social worker may contribute to the ultimate solution. In discussing this point, may I stress the fact that I am referring here to a nurse who has had public health training and to a social case worker who has had adequate training either in a school of social work or through supervised experience. Let us not judge the possibilities of coöperation in terms of our experience with those individuals who are inadequately prepared for their own task.

With this clarification, let us consider briefly the field in which the public health nurse, because of her training, may make an authoritative contribution. These contributions would be somewhat as follows:

Knowledge of medical diagnosis and its significance in nursing treatment.

* Presented at New York State Conference of Social Work, Niagara Falls, N. Y., November 12, 1931.

Knowledge of local resources for medical treatment.

Skill in securing from the physician and the family the medical history and diagnosis of the patient, and information as to the treatment required.

Provision for nursing care.

Ability to educate the family in better methods of living, especially from the health angle.

Knowledge of health significance of certain social conditions.

Similarly, the social worker may make the following contributions:

Knowledge of the social significance of sickness.

Knowledge of local resources for social treatment.

Study of the family's social history and diagnosis of its social need.

Mobilization of community resources for the improvement of social conditions.

Ability to secure better home life from the health, emotional, and economic standpoint.

It is of course obvious that at many points these fields overlap and that either worker may have a considerable degree of knowledge and experience in the field of the other. The important point is that a major responsibility should be assumed by either worker in the field in which her training and experience give her the right to speak with some degree of authority. It is in the region in which both groups recognize an interest and some degree of responsibility that the necessity for clarification becomes necessary.

Consider, for instance, the case of a man who is suffering from tuberculosis and who has a family dependent upon him. The question may well arise as to whether his recovery will be facilitated by a period of complete rest and treatment in a sanatorium, or whether at the moment, the emotional satisfaction of being with his family and partly supporting them through a carefully chosen part-time job with supplementary relief, would be a greater contribution to his recovery. Our joint purpose would be the speediest possible return of the man to normal living, including physical recovery and the greatest possible degree of permanent earning capacity.

Here we have a distinctly social-health problem in which each worker must contribute her knowledge, with that of the physician, as a basis for making the plan a joint plan on which both agree; an agreement as to which worker shall assume the major degree of responsibility and what minor services the other worker may profitably undertake. By utilizing the knowledge and skill of each worker we can develop a more effective plan for the welfare of the family.

COLLABORATION

It may perhaps seem obvious that joint planning is desirable. Many conflicts develop, however, from our lack of clear cut plans for collaboration. May I give two illustrations? First, here is one from the situation in Cattaraugus County during the health demonstration. Here 15 public health nurses were already in the field before a social worker was secured. The nurses recognized the extent and gravity of the social problems they were uncovering and at their suggestion a social worker was appointed. When she arrived, however, little or no attempt was made, apparently, to arrive at an agreement as to the number of cases which she could handle effectively and the type of problem in which she could make the greatest contribution. Instead, the nurses began referring their most difficult and in many cases insoluble problems to her, and by the end of six months she was completely swamped by the avalanche. Feeling the hopelessness of the situation, she did not stop to report her difficulties nor the reasons why action was not taken in individual cases. As a result, the nurses felt that it was not worthwhile to refer families to her. If a decision as to her program had been arrived at jointly and modified from time to time in joint deliberation, the social worker might have been enabled to make a greater contribution to the situation. Here was a poor referral technique, an inadequate understanding of what collaboration should mean which was a distinct handicap to all.

May I stress the fact that I think conflict is apt to focus around the unusually difficult family whose problems baffle us all? Let us not visit on our co-worker's head our sense of despair over our common inability to solve an insoluble problem.

The second situation is one with which I have been familiar in New York City through an effort to secure more effective coöperation between the family agency workers and the nurses who are doing medical social work in the hospitals. After about three years of discussion, these two groups have thrashed out some of the important steps in securing satisfactory coöperation on individual cases which seem to me of value in any social work relationship:

A coöperative understanding between the two agencies concerning the general policies of both organizations. This has taken the final form of a statement by each group of agencies as to the type of case it is able to accept. Workers sometimes refer cases on which they would like "something done," without knowing whether the other organization is equipped to handle such cases. An understanding of the policies and program of work of the receiving agency seems to be a very important part of an intelligent cooperation.

For instance, one of the great difficulties is the question of who is to handle the relief situation. The adoption of the following general policy seemed to clarify some of the points about which friction had developed:

That the part which relief plays in determining referral should be based on the following general policy:

Relief is for all agencies a tool and not an objective or a special function.

Any agency which does social case work should be responsible for making the decision on which its own relief-giving is based. Conversely, no agency prescribes the relief to be given by another agency.

The fact that a sick person is the patient of a hospital does not make it incumbent upon that hospital to meet the normal financial needs and obligations of that patient. Such needs should be referred to the community agency to which the problem is appropriate.

A good procedure for referring cases. While this may not seem as important in smaller communities, it is nevertheless very desirable that each agency know something of the referral procedure of the other organization. When and how do you like to have cases referred to you? Do you want the family sent to your office, or do you want them to be told that a visitor will call? If you accept cases over the telephone, what kind of supplementary and corroborating information would you like to have the referring agency send you by mail? Should workers from both the agencies continue to visit families in which both medical and social work are needed?

Any two groups of workers in the same community may profitably get together to work out such understandings on procedure in referring families which may save both the family and the workers. It would often be an asset to put this in writing and then make it a part of the regular procedure of both organizations.

The need for a clear division of responsibility on cases in which both workers continue to maintain an interest. Our group in New York recommended that in such cases a joint plan be made by the two organizations and that this joint plan be made a part of the record of both agencies; that in case either agency wished to modify this plan, it should do so only after a further conference.

Adequate opportunity for joint conference. In New York City conferences were held by the staffs of hospital social service departments and family agencies in certain districts. In some instances they discussed general policies of relationship; in others they considered, over a cup of tea, families known to both groups in which a difference of opinion had arisen as to the next steps to be taken. It was amazing how a sense of working at cross purposes vanished in the light of greater knowledge of the difficulties which either group faced, and in the recognition of the genuineness of their com-

mon concern for the family. May I point out the importance of having all staff workers and not just executives attend such gatherings, since it is the workers who actually visit the family who need to find a basis for common action.

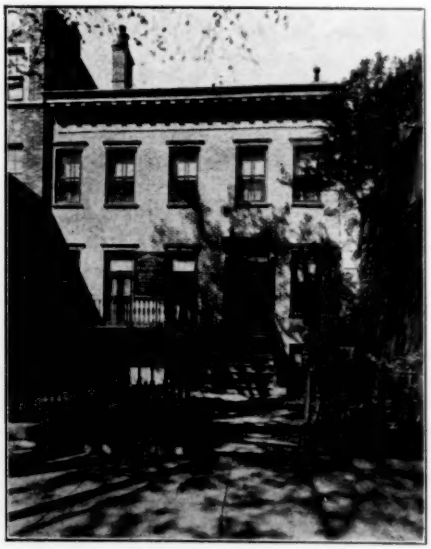
My experience in Cattaraugus County led me to feel that in county organizations with a number of staff workers, it is important that those members of the respective staffs who cover certain districts meet for similar discussion in joint case conferences, with representatives of local organizations.

I should like to emphasize the fact that such joint planning and action are great assets to all workers. Our task is difficult enough at best and we need the stimulus and encouragement which comes from working with others toward a common goal.

We must remember also our obligation to save from unnecessary difficulties the individuals whom we serve. Let us remember the misery which tactless referrals and ineffective cooperation may bring to those whose troubles are grave enough without our adding to them through our own lack of harmony.

To become aware through personal conference of the skills and knowledge of the other groups; to recognize each other's ideals and difficulties and the common concern for those whom we serve; to arrive at some simple but very concrete formulation of the best procedures for relating our work in behalf of individuals and families; to make joint plans and to define clearly the part which each is to play in carrying them out—these are to my mind some of the steps by which team work between nurses and social workers is being made effective.

A NEW OLD HOME



The Albany (N. Y.) Guild for Public Health Nursing is receiving felicitations on the acquisition of this beautiful old home which has been purchased as headquarters for the nursing service. The house is over a hundred years old, and has seen years of gracious living. Indeed, the last family resided there forty-seven years. In addition to repairs, only one partition had to be made to make this home ideal for nursing requirements. There are six rooms for clinics and offices downstairs, and the nursing offices, including teaching center and board room, are on the second floor. Furnishings were largely donations from the Board; the chairs for the board room are over 125 years old, still in good condition, given by one of Albany's oldest families. The house is centrally located, and its purchase, which appears to be a wise investment at this time, was effected by borrowing money, using as collateral the mortgage investments in the Association's endowment funds. As these mortgages fall due, the money will be applied on the loan, instead of reinvested.

Organized Hourly Nursing in Chicago*

By MIRIAM AMES
Executive Director, Joint Committee on Hourly Nursing, Chicago, Illinois

"RASTUS," said the young man to the driver of the mule team as they were proceeding in leisurely fashion along a road in old Virginia, "you are so proficient with your whip, let's see you flick that gray lump from the eaves of this barn we are going to pass."

"No siree, Boss," replied the driver, "dat's a hornets' nest and dey's organized."

Nurses, who day after day are working with one group or another, whether it be community, city or state, continually demonstrate the value of organization. Well organized groups fearlessly attack their problems, even stirring up a hornets' nest if need be.

So many inquiries have come to us in the past few months with respect to the organization of hourly appointment service in Chicago, that we believe this article will clarify matters and answer many of the questions.

"I am interested in organizing hourly nursing, how shall I begin?" is a favorite question. "Our registry wishes to offer hourly nursing service as one of its activities, what would you advise?"

Without a knowledge of what already exists in the community or what the demand is, it is not safe to advise anyone to copy the kind of organization we have in Chicago. Besides, we are still carrying on the fact-finding process; still in the experimental stage. It is too soon to be able to demonstrate that this is an ideal set-up for this type of service. *Caveat emptor,* until we have definite recommendations to offer. These will not be available until we have the service reviewed objectively by someone with an entirely disinterested and impersonal viewpoint. However, we are continually making observations which we are prepared to pass on to those who inquire. In the meantime, if you are considering organizing this service, we refer you to the national nursing organizations where there is a fund of data gathered by the Joint Committee on the Distribution of Nursing Service.**

HOW THE PLAN EVOLVED

In the event that many do not know why the Chicago demonstration of hourly appointment service was inaugurated, it is necessary to explain something of its history and purpose.

Five years ago, when the demands upon the registry for appointment service were noticeably increased, a group of lay women, members of the Central Council for Nursing Education and professional members of the First District Illinois State Nurses' Association, agreed to sponsor an hourly appointment service under the name of Joint Committee on Hourly Nursing. The extension of knowledge and promotion were vested with the lay group and the interpretation of the service to physicians, patients and nurses, was left to the professional group.

The Chicago Visiting Nurse Association had previously discontinued this type of service because there were so few requests for it. The Nurses' Official Registry where nurses were always available seemed the logical place to center this activity. The calls could be directed to the hourly nursing service if such service were not familiar to the patient and could be handled with relative ease.

* Approved for publication by the Joint Committee on the Distribution of Nursing Service.

** See The Public Health Nurse for April and May, 1931. The N.O.P.H.N. has a loan folder on hourly appointment service.

The project was launched and the salary of four staff nurses guaranteed. One nurse acted as supervisor and in addition did considerable promotional work. Although a program for publicity was carried on during the first year, the work did not progress rapidly enough to meet expenses, with the result that at the end of the first year all but one staff nurse were dropped.

Nothing daunted, the committee of splendid women sponsoring the work continued to think of ways and means to carry on, because experience had proved that physicians and hospitals using the service were well satisfied and their patients adequately cared for. The results of the second, third and fourth years indicated that the service, small though it was, almost paid for itself. It was obvious, therefore, that with a sufficient number of calls the service could be made self-supporting. The great difficulty lay in making the service generally known to the public—and there was no money for this.

About this time the costs of medical care were agitating the best minds in both the medical and nursing professions and the public was concerned with seeing results. Hourly appointment nursing, advocated by the national nursing organizations, seemed to be one way to reduce the cost of nursing care to the person of moderate means. It was this particular phase of the Chicago project which fired the interest of the Julius Rosenwald Fund.

THIS IS OUR AIM

The Julius Rosenwald Fund was interested in contributing aid if an experiment could be conducted to determine whether or not hourly nursing service is as valuable as it is thought to be. An experimental period of, say, five years should prove one of two things, namely: that people have not made use of hourly nursing service because they know little or nothing about it, even though they need it; or that hourly nursing service is *not* a type of nursing service which is needed. This, then, is the purpose of the Chicago demonstration. The Julius Rosenwald Fund is gambling on the outcome and will be equally interested in having an affirmative or negative decision.

When the Fund agreed to underwrite the experiment it was understood that a substantial amount of the sum was to be apportioned to making the service better known. The public was to be given every opportunity to know first hand, and not by chance, that this type of nursing was available.

HOW WE ORGANIZED

The grant from the Julius Rosenwald Fund became available on January 1st, 1931, the date of reorganization. The commitment was not to exceed the sum of $11,500.00. The agreement was worded thus:—

"It is understood that grants from the Fund will be devoted to (a) the promotion expenses of the hourly nursing program during this period, and to (b) the operating deficit. It is understood that the operating deficit shall be counted as being in addition to such deficit as was incurred and paid for by the hourly nursing committee during the year ending January 1, 1931, and that grants from the Fund will not meet more than half of the operating deficit for the year, beginning January 1, 1931."

The Joint Committee on Hourly Nursing engaged an executive director who was to divide her time between organization and promotion. A second staff nurse was appointed, one who had had a course in public health nursing. Both nurses have enviable records in private duty nursing.

In reorganizing the work, the American Nurses' Association was appealed to and the service was made to conform to the "Maximum Standards for Hourly Nursing." The Joint Committee on Hourly Nursing wisely decided to keep the organization simple.

The Board consists of seven lay members, representatives from the Central Council for Nursing Education, and four professional members from the First District Illinois State Nurses' Association.

The Medical Advisory Committee consists of ten members, all specialists in their particular lines of endeavor.

A Community Committee of sixteen members was appointed at once for the purpose of "extending knowledge and bringing constructive suggestions for improvement to the executive director." Within the past six months, the Community Committee has been enlarged to more than 100 members. We still have to rely to a great extent upon "word of mouth" publicity and as one board member said, "One hundred wagging tongues are better than a dozen."

Publicity counsel was engaged with responsibility for regular newspaper publicity, notices to club bulletins and various other media in order to keep "hammering" at the idea. It was for publicity reasons that the name was shortened to "Hourly Nursing Service" from "Hourly Appointment Nursing Service."

ADMINISTRATION

A record system was installed for our own protection and for the purpose of gathering data. From the careful analysis of our records, we hope to determine a number of facts that may be helpful to other organizations.

An experimental area on the Southside of Chicago was determined upon and special effort was to be made to build up the service within its boundaries. But calls would be taken from any district in Chicago and the Village of Oak Park.

Definite policies were established with regard to charges. Our fees are $2.00 for the first hour, $1.00 for the second and 50¢ for each additional hour. A special relief service at $4.00 for four hours is offered in order to provide relief for the nurse who is engaged for twenty-four hour duty. The hours are reckoned from the time the nurse enters the home until she is ready to leave.

Equipment for the staff nurses was standardized. A bag similar to a visiting nurse's bag is used by the staff. A uniform smock was chosen in place of a uniform dress. Street clothes are worn.

Other policies decided upon, relating to the necessity of working under a physician's direction, hours of work, vacation, etc., are similar to those in other public health nursing organizations.

ADMINISTRATIVE PROBLEMS

How a city-wide program can be carried on with so small a staff is a question which naturally arises. The answer is that at present there are not sufficient calls to keep more nurses busy on a full-time basis.

One difficulty in administering a service such as this is that most patients request nursing care during the morning hours. Moreover, the calls are often in distant parts of the city so that a "floater" nurse is impractical. The districts are large and travel is time-consuming. Another difficulty of administration is that it is not possible to count on eight hours of nursing service every day. For example, a nurse may have all her appointments filled during the morning and perhaps only one appointment in the afternoon for several consecutive days. Unoccupied hours are spent in making contacts with physicians, and although this is necessary, it is not lucrative. You may ask why the calls cannot be distributed throughout the day. They can be, sometimes, after the patient becomes acquainted and prefers her nurse to any other. But, if you are advertising an appointment service and the patient insists upon having the nurse at a certain hour, you are practically under obligation to give her service when she wants it. The plan of administration would not be so expensive if the nurses could be sent to make other calls in the neighborhood as they do in a visiting nurse association. Volume of service would solve our problem to a great extent.

We estimate that our income for this year will just barely cover the expense of two staff nurses. It will be necessary for the next few years, therefore, with large promotional and operating expenses, to have the organization underwritten.

ENCOURAGING ASPECTS

Publicity: Other organizations carrying hourly appointment service have felt that with sufficient publicity the service would develop more rapidly. The first noticeable encouragement after the regular publicity program began on January first, last year, was a steady increase in the number of new cases. At the end of six months the service had more than doubled. Publicity, continuous and well directed, seems to justify our belief in its efficacy. We cannot help wondering why even larger numbers of persons do not demand the service, and this we are attempting to discover. It is true we have not advertised to any great extent. Perhaps we should. At least we know we have not found the magic button that sets the whole mechanism in motion. Regular publicity in newspapers, bulletins, magazines, distribution of leaflets, radio talks, personal contacts and word of mouth publicity all have a definite place. Physicians must be reminded of the service periodically. We shall make a tremendous contribution if we can discover what particular form of publicity hourly nursing needs to "put it across." A service which has such a strong appeal to the average person who hears about it for the first time should grow by leaps and bounds.

Coöperation with Agencies: We note an increasingly wide interest in the project among nurses, hospitals and various other organizations. What they have done to help further the work may be of interest. The hospitals have been supplied with our literature. Some hospitals enclose one of our leaflets with the final bill to every private patient who may need this type of nursing care after he goes home. Others place a leaflet under the glass top of the bureau in every private room. Satisfactory service has won the confidence of physicians, with the result that they call us again and again. Private duty nurses are thinking in terms of hourly nursing and are referring patients for the part-time service which is required after they are dismissed. Ten per cent of our patients whose condition is unimproved are transferred to the care of private duty nurses. The Chicago Visiting Nurse Association refers patients who can afford our fee. The Hourly Nursing Service in turn refers patients to the Visiting Nurse Association. Some of the patients enter hospitals when they can no longer be cared for under the hourly plan. A few engage practical nurses and the remainder are cared for by members of their families.

Nursing Advantages: One particularly good feature is that almost without exception the nurse who originally visits the patient, carries her throughout her entire illness. We have practically eliminated what we believe is a very serious drawback: a change of nurses. One of our patients has been attended by the same nurse since last January.

Unless unavoidably detained by traffic difficulties, the nurse can be depended upon to keep her appointment to the moment. We always secure the telephone number when the call is taken in the office or upon the first visit, so that the patient may be informed if the nurse will be late for her appointment. Visits to not-at-home patients are practically eliminated due to the telephone communication.

The nurses telephone to the office after their last morning appointment and after the first afternoon appointment so that unnecessary travel is minimized. We maintain an eight-hour day and if evening calls are necessary, the time is made up to the nurse during the next day.

The majority of calls are made in an hour. Our records indicate that the first visit may be longer for obvious reasons. The nurse must systematize her work and establish a routine. Over fifty different combinations of treatments have been found in the analysis of our records and all have been given within an hour.*

* See *Hygeia*, December, 1931.

It takes a good bedside nurse to succeed in hourly nursing. The personality of the nurse must be acceptable or the patient will not ask her to return. If Miss So and So is not satisfactory, we cast about to find a nurse who is. Fortunately, this experience is extremely rare.

The nurses must be tactful and they must have good judgment. They keep in touch with the doctor and of course are under his direction. We refused care to a would-be patient who prescribed her own treatment and when told why we could not give care, she said: "I should like to have a nurse who has independence enough to act without a physician's order."

The nurses must be willing to fill the need as it arises in the home. It may mean cooking and serving a meal for the patient, making dressings or giving a shampoo in bed. We accompany patients to doctors' offices or accompany patients transferred in ambulances. We have "specialed" patients in hospitals; substituted for doctors' assistants; cared for transients in hotels and even chaperoned patients between trains. While some of the duties appear to be not strictly nursing they are necessary if we are to discover what the need is. Instruction in classes for expectant mothers is paid for on an hourly basis. We hope to play an important rôle in the follow-up care of cancer cases in the future.

Our service shows that we have many cases including medical and surgical conditions of both acute and chronic illness. Chronically ill patients are sometimes so ill that they cannot be properly cared for by a member of the family and frequently this type of illness is more of a financial drain than acute illness because of its long duration. Our service to the chronically ill is an important phase of our work. Thus far we have had few post partum cases, but we hope to develop our maternity service as we become better known.

One service we offer is particularly valuable and acceptable. In cases where there is a twenty-four-hour nurse, and she is to be relieved every afternoon for four hours, the hourly nurse may be engaged for special relief service. We give the patient a fair guarantee of having the same relief nurse every day.

CONCLUSIONS

We are not prepared at present to say the experiment has proved a success. There are too many factors still to be considered. We have not succeeded in reaching large numbers of patients—we must discover why. Our fees may be too high; we may have to advertise extensively; our organization may be faulty. We must try a little harder and carry on the experiment a little longer, before we announce a plan which is applicable generally.

We do know the value of having a good board of directors of both lay and professional members who are willing to work and who have vision. We are continually enlarging the scope of activities due to their efforts. Good organization makes for stability.

We know that hourly nursing adequately fills a need for patients who require an hour or two of nursing care, but who do not need a full-time nurse.

We find that our service has reached many families who comprise "the backbone of the nation," but the majority of calls this year have come from those who in more prosperous times, would have had not only one but two nurses on full-time duty. The charges for the service indicate that it is for the person who can afford to pay for full-time nursing care but who does not require it. He is the man of moderate means. He does not go to a London tailor when he knows an excellent tailor around the corner, nor does his wife go to a specialty shop when she can buy chic gowns in a department store for less money. It is for persons of intelligence, accustomed to the amenities of life, that skilled hourly nursing service is designed.

Detroit Sets an Example in Membership Enrollment

THREE hundred and sixty-five public health nurses on the staff of the Detroit Board of Health have voted, through their staff council, to make individual membership in the National Organization an annual requirement.

Coming, as this announcement did, after six weeks of almost overwhelming response to the N.O.P.H.N. special membership enrollment, it is indicative of the spirit of coöperation and support which has been given the National Membership Committee since October.

In a letter to Miss Tucker telling of the decision, Miss Elsa Pankratz, Chairman of the Staff Nurses' Council of the Detroit agency, wrote:

"We are very glad that the membership drive came this year. While some have always been close to the N.O.P.H.N., this provided an unusual opportunity for bringing it to the nurses who have been more recently appointed to our staff. . . . The motion carried with only three dissenting votes."

Miss Pankratz has expressed the viewpoint of many others who have written of the need for closer coöperation among nurses and among interested laymen.

Limitations of space permit publishing only a few of the pledges of support which have come from various parts of the country:

"Just a hasty line to tell you that I will do all I can to promote the drive for membership in the N.O.P.H.N."—S. C. Titus, Dean of School of Nursing, Vanderbilt University, Nashville, Tenn.

"I assure you that the Indiana State Nurses' Association will be very glad to cooperate in every way possible . . . in this membership campaign."—Gertrude UpJohn, President.

". . . With every wish that Montana's public health nurses will fall into line with 100 per cent membership in the N.O.P.H.N."—Edith L. Brown, Secretary, Montana State Nurses' Association.

". . . Our S.O.P.H.N. will do all in our power to promote the membership drive and I think under the chairmanship of Miss Deutsch we shall make a good showing."—Helen D. Halvorsen, President, California S.O.P.H.N.

"We have definitely set our goal for staff membership in the N.O.P.H.N. to be nothing less than 100 per cent."—Cathlena A. Cooper, Director, Syracuse (N. Y.) V.N.A.

"We hope to have 100 per cent Metropolitan enrollment in the N.O.P.H.N. and subscription to the magazine, in these three states, among Metropolitan nurses."—Ruth H. King, M.L.I. Territorial Supervisor, Cincinnati, Ohio.

"I want especially to tell you that the Hartford V.N.A. has come across 100 per cent for membership. . . . Our group numbers forty-seven."—Elizabeth Hanson, Tuberculosis and Social Hygiene Supervisor, Hartford (Conn.) V.N.A.

"I assure you I will give this membership drive all the support and coöperation possible."—Inez M. Wilson, Florida State Nurses' Association.

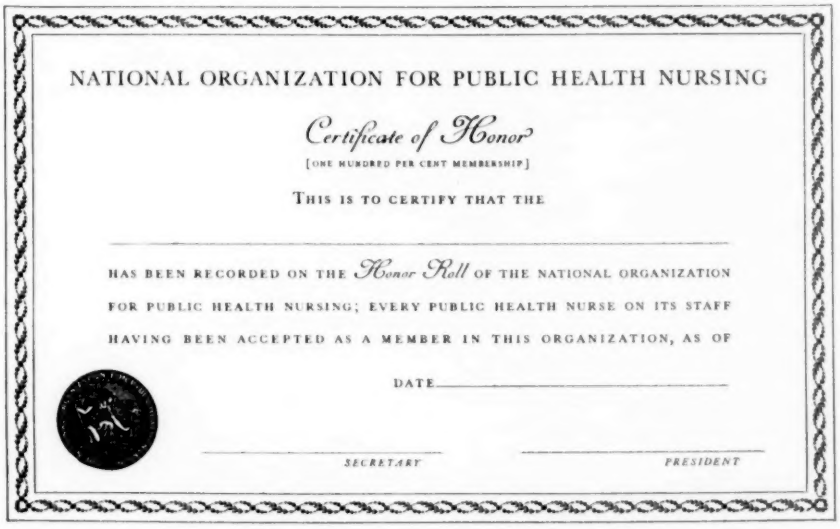
"We are very much interested in doing everything possible to coöperate to the end that every public health nurse in New York State shall join your Organization."—Emily J. Hicks, Executive Secretary, New York State Nurses' Association.

". . . The real campaign has just started and by now you probably have received the dues for twenty-six members, sent in the other day. Just watch the number grow."—Katherine Hagcuist, President, Texas Organization for Public Health Nursing.

Doubled Membership Means Redoubled Strength

CERTIFICATE OF HONOR

To each local agency the staff of which has reported 100 per cent nurse enrollment in the organization, the N.O.P.H.N. will send a certificate, a copy of which is reproduced here. As many local organizations will take pride in displaying their certificate that all may know of their national standing in relation to the whole public health nursing movement, the N.O.P.H.N. has designed a certificate which is suitable for framing and which should prove decorative. The seal and border are done in color and the size is six by nine inches.



NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Certificate of Honor

[ONE HUNDRED PER CENT MEMBERSHIP]

THIS IS TO CERTIFY THAT THE

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HAS BEEN RECORDED ON THE *Honor Roll* OF THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING; EVERY PUBLIC HEALTH NURSE ON ITS STAFF HAVING BEEN ACCEPTED AS A MEMBER IN THIS ORGANIZATION, AS OF

DATE_____

_____ *SECRETARY*

_____ *PRESIDENT*

HONOR ROLL

One hundred per cent staff membership in the N.O.P.H.N. is an enviable goal for any local organization. It is a tribute both to the initiative of the staff attaining it and to the place of a national organization in the public health nursing movement. PUBLIC HEALTH NURSING is proud to publish a list of the agencies reporting the attainment of this goal, and the N.O.P.H.N. rejoices in this excellent beginning among local public health nursing agencies.

Albany Guild for Public Health Nursing
Albany, New York

Atlantic City Visiting Nurse and Tuberculosis Association
Atlantic City, New Jersey

Cleanliness Institute
New York, New York

Detroit Department of Health (Pledged 100%)
Detroit, Michigan

Erie County Public Health Nursing Service
Buffalo, New York

Indianapolis Public Health Nursing Association
Indianapolis, Indiana

Instructive Nursing Association
New Bedford, Massachusetts

Middletown District Nurse Association, Inc.
Middletown, Connecticut

North End Clinic
Detroit, Michigan

North Penn Community Center
Ambler, Pennsylvania

HONOR ROLL

[*Continued*]

Smithfield Public Health League
Georgiaville, Rhode Island

Social Welfare League
Waterloo, Iowa

Topeka Public Health Nursing Association
Topeka, Kansas

United Workers of Norwich
Public Health Nursing Department
Norwich, Connecticut

Visiting Nurse Association
Buffalo, New York

Visiting Nurse Association
Fitchburg, Massachusetts

Visiting Nurse Association
Hartford, Connecticut

Visiting Nurse Association
Holyoke, Massachusetts

Visiting Nurse Association
New Rochelle, New York

Visiting Nurse Association
Saginaw, Michigan

Visiting Nurse Association
Lowell, Massachusetts

Village Welfare Society
Port Washington, L. I., New York

If the staff of your organization is enrolled 100 per cent, be sure to report it to the N.O.P.H.N. to ensure your agency's being listed in a subsequent Honor Roll.

CROWDED LIVING CONDITIONS

Dr. G. S. Plant has discussed in *The American Journal of Psychiatry* certain mental habits which in his opinion are definitely related to overcrowded living conditions. He bases his conclusions upon six years of experience as director of the Essex County (New Jersey) Juvenile Clinic, whose clientele includes children from both crowded urban centers and sparsely settled rural sections. In the children from crowded quarters, he has noted the following general tendencies: (1) an overdependence upon external resources due to the fact that the child never is alone and hence has practically no opportunity to develop a self-contained, self-sufficient individuality; (2) lack of any idealism with regard to the people around them, notably the parents, a result of living in such close contact with them that it is difficult to build up any hero-worship or identification phantasies about them; (3) lack of any idealism about sex, with the consequence that the child grows to value the physical sex life *per se*, rather than as a symbol of personal relationships; (4) "mental strain," due to the constant necessity of adjusting to other people, and evidenced in restlessness and irritability; and (5) inability to objectify themselves or the world around them—"they are so much in life that they cannot look at it."

The prevalence of these tendencies among children subjected to crowded living conditions suggests several interesting questions—for one, the question whether these traits persist into adult life. Certain of our present-day social phenomena would seem to indicate that this is the case, but here, again, not enough data are available for a positive statement.

—Abstracts, *Mental Hygiene*, July, 1930.

What Is New in Maternity Care?

By ANITA M. JONES
Assistant Director, Maternity Center Association, Inc., New York, N. Y.

ONE hears on every hand the question, What is new in maternity care, in baby care, in child care? until one wonders if the constant striving for the new in homes, furniture, radios, automobiles, clothes and what not, which is characteristic of this land and age, has taken possession of nurses, too.

True it is, that progress comes because some one is continually searching for the new, but this general clamor for the new has so often come to mean a lack of interest in the old and a wasteful discarding of it, that it is not strange if the thoughtful observer of maternity work sees a failure to apply what we already know. The truth is, there is very little that is new in maternity care—no new discoveries of causes, no dramatic cures for albuminuria or septicemia—nothing new except perhaps a few minor details of technique.

OUR KNOWLEDGE IS OLD

At least fifteen years ago obstetricians knew that every pregnant mother needs medical supervision from the beginning of pregnancy until she is able, and understands how, to care for her baby and can resume her usual activities and responsibilities. They knew, too, that such care would have saved the lives of two-thirds of those mothers who have died each year having babies. It was no academic theory, for here and there throughout the country such service has been provided for comparatively small groups, and the results have emphasized the life-saving value of adequate care. At an even earlier date, Dr. S. Whitridge Williams had said that the women of America would have good maternity care when they themselves knew what adequate care was and demanded it. The attendance at well-conducted mothers' classes seems to have proved that the pregnant woman is eager for care and instruction, for it is usually a great effort to get to these classes.

And yet, today there is not a community where adequate maternity care is available for every mother at a price she can afford to pay.

OUR APPLICATION—INCOMPLETE

Those of us who have been doing maternity work for many years are convinced that adequate maternity care can be made available in almost every community where the doctors, hospitals, nurses and laymen will work together to provide it.

The Federal Children's Bureau, state health departments and the Maternity Center Association are publishing facts about the maternity situation in this country, about the need for and value of adequate care of mothers, what constitutes that care, and are helping thus to prepare the layman to do his part. The leading medical schools are teaching better obstetrics. Obstetricians are writing in medical journals and speaking at medical meetings and the medical groups themselves are holding post-graduate institutes and clinics to keep the whole subject before practicing physicians so that all doctors may be ready to give better maternity care. The number of hospitals conducting prenatal and postnatal clinics and classes and urging their patients to come to them early in pregnancy is increasing. Very few, however, are admitting all patients to their clinics and classes. The sooner this practice is adopted, or some other plan evolved, the sooner will midwives' patients have the benefit of medical examinations which may detect abnormalities and physical defects in time to treat before they injure the mother or baby.

Private doctors have been hesitant

about urging patients to come to them for fear it might seem like self advertising. To the public health nurses, therefore, falls a large part of the responsibility for teaching the individual patient about maternity care and the need of placing herself under medical supervision early in pregnancy. For the same reason, in small communities where there is no full-time health department, public health nurses may have to be responsible also for stimulating the community to organize to improve the care it provides for its mothers.

These two tasks—even though we have known about them for some time—might well be accepted by public health nurses as the new aims in maternity care. Indeed every nurse—for what nurse escapes contact with expectant mothers and fathers—can teach individual patients the facts about maternity care, facts which, as so often happens when the truth is aired, will wreck the complacency with which people now accept the deaths and illnesses of mothers and babies as the "working of Fate." No one can do more than the nurse to hasten the day when "the women of America will have good maternity care because they know what adequate maternity care is and demand it." Nothing new in maternity care is needed for this, only such a thorough understanding of the old as will challenge every nurse, every nursing organization and every school of nursing.

A GOOD MATERNITY SERVICE—THE BEST TEACHER

The most convincing teacher in any community is a thoroughly good maternity nursing service—whether given by one nurse or a thousand. Constant review by nurses—individually and in groups—of all that is taught in Van Blarcom's *Obstetrical Nursing* and Zabriskie's *Nurses Handbook of Obstetrics,* with frequent references to such medical books as De Lee's *Obstetrics for Nurses* and Williams' *Obstetrics,* staff conferences and consultations with the doctors about individual patients, and nurses' institutes in maternity care, will improve the work of individual nurses and make their teaching more effective. Supervisors and directors of public health nursing services can do much, not only to improve the nurses' understanding of maternity care, but also to establish good working relations with the medical profession, if they will ask doctors to explain procedures to nurses who work with them, and invite doctors to staff conferences to lecture or discuss a difficult case.

Studying the resources for maternity care in each new community in which the nurse finds herself, and learning all the details of the organization and administration of the successful maternity work that is being done elsewhere, will give nurses the basis for helping a given community to make plans to improve its service. Communities are so different that work which is successful in one place can seldom be done in the same way anywhere else; but the original plan can be adapted to the nature and needs of the new community, if the fundamentals of the original service are understood.

When every woman goes to a doctor as soon as she thinks she may be pregnant, sees him frequently throughout pregnancy, learns to care for herself and to prepare for the baby, has a nurse as well as a doctor at delivery, has rest, nursing and medical supervision until the doctor is satisfied that she is able to care for her home and family and knows how to care for herself and her baby, then, and only then, can we feel that all that is now known about maternity care is being applied. Every step that we take toward that ideal will be creating "something new in maternity care," and should give us the stimulation that comes with accomplishment, and the courage to persist.

The Responsibility of the Visiting Nurse Association to the Well-to-Do Patient*

By BEATRICE SHORT

Superintendent, Public Health Nursing Association, Indianapolis, Indiana

HAS the visiting nurse association a responsibility to the well-to-do patient? Should it supply him with hourly appointment nursing service in his home?

It is not necessary with this audience to go into a discussion of the need for such a service. We know from reports on sickness, the reports of the Committee on the Costs of Medical Care, from the histories of patients, that many people in our communities today, financially independent, do not have the nursing care they need to help them to recovery or to protect some overburdened member of the family. Why? Because they do not feel they need or can afford the full-time services of a private duty nurse. But they could afford a nurse for an hour or so each day at a reasonable rate. Private schools frequently have no nursing service. They do not need a full-time nurse. They and others could use an hourly service. And we believe that such a service should be made available to them.

Thoughtful citizens should be actively interested in an hourly appointment nursing service for their communities just as they are concerned in securing good hospital facilities. Miss Miriam Ames of Chicago has spoken of hourly appointment nursing as "a civic enterprise." Does not the visiting nurse association, a civic organization, have a responsibility to provide that service?

Numerous reports on how hourly appointment services are being conducted have been published.** As a guide to those conducting or contemplating such a service, the Joint Committee on the Distribution of Nursing Service has set up some tentative standards. The report of the committee states:

"Whether or not an hourly appointment nursing service is sponsored by a visiting nurse association or by an official registry or other agency, the principles already obtaining in visiting nurse associations should govern its development.

"The principles and methods found good in standard visiting nurse practice today, by which skilled nursing care is distributed effectively and economically, demonstrate the basis on which sound hourly appointment nursing should be established."

But meeting the requirements of the service does not answer the question of responsibility.

In seeking to determine this, it is well to examine the trends in the modern public health nursing movement, and the broader field of social work. Visiting nurse associations, like other social agencies, are made possible by socially minded people within the community, frequently through the medium of the Community Chest. Public opinion varies somewhat in different communities as to the objectives in social work but the trend is discernible in conference discussions. Speaking before the Citizens Conference on Community Welfare held at Washington in 1928, C. M. Bookman, who was then President of the Association of Community Chests and Councils, said:

"The main purpose of social work is to assist in building up a society in which each citizen has the fullest opportunity to develop his capacity to live a complete life. In the last analysis social work's preventive and constructive program has to do with the

* Presented at the General Assembly of the Iowa State Association of Registered Nurses and the meeting of the Midwest Division of the American Nurses Association, Des Moines, Iowa, October, 1931.

** See The Public Health Nurse: August, 1927; January, March, April, May, 1928; April, 1930; March, May, 1931.

establishment of proper standards of life—standards of life that will give sound bodies and minds, educational opportunities, spiritual, cultural development, upright character and economic independence to everyone."

It is a long cry to the day when "philanthropy" and "charity" comprised the whole field of social work. Agencies have had to change their plans of organization, their standards of work and even their aims to meet changing needs, our better understanding of those needs and the community's responsibility toward them. We have religious, character-building, welfare and health agencies, all supported by the general public, in many communities through a common Community Fund. These agencies serve all classes of citizens. As Mr. Bookman says, "Each agency must first be concerned with the service for which it is organized, but it must see that complete fulfillment of this service depends upon a well organized community program."

Our early visiting nurse associations confined themselves to giving service to the poor. But as their understanding grew, our boards changed their objectives and programs. For many years now it has been a basic principle of such organizations that the service should be available to everyone, and that those who could pay for service, should do so according to their means. Have not such associations then, a responsibility to provide itinerant nursing care to the sick in their homes or others in the community who need and can pay for service?

If we examine the articles of incorporation of several visiting nursing associations, we find that the purpose for which they were organized varies somewhat, but the statement in all the cases I know of, is sufficiently broad to permit associations to change their programs to meet changing conditions.

One of the difficulties in public health, indeed, in the whole field of social work, has been the duplication of agencies with the constant pyramiding of overhead and duplication of service. Agencies are not always able to provide all the services their communities need as judged by our modern standards. But an hourly appointment service, well administered, should be self supporting. The program can be efficiently and economically fitted into the work of the visiting nurse association without curtailment to the regular services, and every family served becomes more interested in the other services of the association and the social work program of the community.

At present this service is being given in various cities under the auspices of several agencies: the nurse's official registry, the visiting nurse association, a joint committee representative of interested groups, and a hospital. The size of the city, the community's traditions and the interests of its leaders are all factors in determining how the service will be developed. But if it is developed in accordance with the tentative principles outlined by our Joint Committee on the Distribution of Nursing Service, then the organization back of it becomes a community agency, whether or not it is a member of a community fund.

Hourly appointment nursing service seems, then, to be a natural evolutionary step for visiting nurse associations in developing sound community programs to meet changing economic and social needs. Where conditions are such that it seems unwise for the association to offer an hourly service, it would seem that the association still has a responsibility toward it. Should it not then take active steps to interest others in providing it, and in coöperating in every way possible to make the service a success? For the service is needed, and the visiting nurse association, organized to give itinerant nursing service to the community, has a responsibility to see that such a service, meeting the needs of the well-to-do citizen, is available to him.

Are Infant Feeding Methods Changing?

Editorial Note: This is the symposium of opinions from pediatricians continued from the December number of PUBLIC HEALTH NURSING.

From Chester A. Stewart, M.D., Minneapolis, Minnesota:

A consideration of the long list of foods employed in the feeding of young infants reveals only one, namely breast milk, which has successfully withstood the test of time and trial without surrendering its place as the most universally satisfactory of all infant foods, and without being greatly changed or improved as the result of our modern scientific discoveries. As far as quality and chemical composition is concerned the nursing baby of the present generation receives milk from his mother which is essentially identical to that obtained by infants ages ago from the savage human breast. The progress of science made as the centuries have rolled by has given us a more exact knowledge of the chemical composition and of the method of secretion of human milk and also has forced upon us the realization that the milk of each race is specifically adapted to supply adequately the nutritional requirements of the offspring of that particular race.

With respect to artificial infant foods, " styles " have changed repeatedly in the past, and are still changing. Thus many once popular, favored, and accepted formulas have been discarded to be replaced temporarily by other concoctions which later have suffered a similar fate. These changes have applied in a considerable measure to modifications of, and additions to cow's milk. A partial list of the milk formulas once widely used or still in vogue, which reveals some of the varied attempts made to produce a satisfactory infant food, includes top milk preparations, simple dilutions of whole cow's milk, homogenized milk, condensed and powdered milk, buttermilk mixtures, Bulgarian milk, protein milk and various formulas of acidulated milk. The changing " styles " in artificial feeding have resulted in the development of formulas that undoubtedly are now superior to those used a generation ago in supplying the nutritional requirements of the infant. One of the more recent developments included the addition of various acids, particularly lactic acid, to preparations containing cow's milk, and today the use of lactic acid milk formulas is rapidly gaining favor, particularly since these preparations are proving to be exceedingly satisfactory in promoting excellent nutrition and growth of young infants.

SUGAR STYLES

The choice of the most suitable sugar to use in lactic acid formulas probably has not been settled finally. Differences of opinion exist as to the superiority of lactose, maltose or dextrose although at present the last two sugars mentioned above are most generally used. Two or three decades ago lactose was employed quite widely as the sugar of choice in infant feeding, but lost its popularity as the result of clinical observations which suggested that certain nutritional disturbances associated with gastro-intestinal symptoms resulted from toxic properties of lactose. Apprehension spread quite rapidly regarding the use of this sugar, and clinicians quickly switched to dextrins and maltose. More recent work is dispelling the fear previously instilled with regard to lactose by placing more correctly the cause of gastro-intestinal disturbances either upon enteral and parenteral infections, or upon diminished digestibility of ingredients of the formula other than lactose. Based on clinical experience, Jarvis recently has recommended the use of lactose as the sugar of choice in artificial formulas, and points out that the lactose-fed infant although seldom fat, resembles, but does not equal, the breast fed baby in firmness of tissue and resistance to infections.

Furthermore, he feels that the use of this sugar in infant feeding distinctly lessens the tendency for clinical dehydration to occur following the development of parenteral gastro-intestinal disturbances associated with acidoses. Recently Gerstley has reported that the addition of the proper amount of lactose to the formula results in stools that are clinically and chemically not unlike the stools of infants fed on breast milk.

Studies such as these may foreshadow the return of lactose to favor as the preferred sugar to be used in the infant diet. Therefore, the next popular "style" in infant feeding may feature formulas composed of acidulated cow's milk to which lactose is added. Since the chemical composition of milk is dependent in a considerable measure upon the nutrition of the cow, artificial formulas in the future may undergo further improvements through proper supervision of the diet of cattle so adjusted that the milk they supply more nearly approaches fixed uniform standards with respect to chemical composition and to maximum vitamin content. The ultimate goal of all the changes and improvements which have been made in formulas used for feeding infants is eventually to produce a milk mixture which approaches the perfection characteristic of breast milk in fully supplying the nutritional requirements of the baby. At the present time this goal has not been fully attained.

DIFFERENCES IN CHEMICAL COMPOSITION

Tremendous differences with respect to chemical composition and to distribution of calories available from proteins, fat and carbohydrate exist between human and cow's milk, the significance of which with reference to perfect nutrition is not thoroughly understood. It is generally felt that these differences are specifically related and adapted to the special nutritional requirements of the offspring of each species or race. The ash of dog's milk is reported to have exactly the same chemical composition as the ash of the body of the newborn puppy, and therefore, is perfectly adapted to the construction of new puppy tissue. This can hardly be a mere chance arrangement but rather a purposeful condition; and similarly the special composition of human milk in that it differs chemically from other milks, no doubt has some direct relationship to the nutritional requirements of the infant.

It is known that breast milk contains all the mineral salts needed by the normal infant with the possible exception of iron. The infant more completely utilizes the calcium of breast milk than that of cow's milk, although less of this mineral, as well as of phosphate, is present in the former as compared with the latter. The buffer value, or the capacity to neutralize gastric acid is much lower for human than for cow's milk, and the rennin of the infant's stomach is said to be specifically adapted for the coagulation of the casein produced by the female of the same race.

Immune bodies have been demonstrated as being present in the colostrum in higher concentration than in the blood, and possibly may have an important though unproved bearing on the resistance of the infant to infections. Recently a substance has been discovered in cow's milk called a bacteriostat, which inhibits bacterial growth and is bactericidal to certain pathogenic microorganisms such as the scarlet fever streptococci. Whether or not a similar substance is present in human milk is unknown, and what its bearing on the health of the infant might be, is problematical. When one considers the delicate chemical (and immunological?) provisions made by nature in supplying through the breast milk the exact requirements of the child, it is easy to appreciate how difficulties may arise upon venturing to disturb these relationships by placing the baby upon an artificial feeding. The resultant nutritional disturbances are evidence that cow's milk is far from being a perfect substitute for human milk, and the changes which have been made in the past in artificial formulas stand as

testimonies to the recognized failure of these preparations to equal the food obtained from the human breast.

Although breast milk in general is the most satisfactory of all known infant foods, it is not always composed of a fixed unvarying chemical mixture. Variations in its composition have been noted in different mothers, and in the same mother at various stages of lactation. The effect of these differences and variations upon the infant's wellbeing is rather uncertain. Alien proteins may appear in breast milk and are thought to bear a relationship to eczema, urticaria and asthma seen in certain infants. For example, after an egg diet, human whey may contain as much as one part in a million of apparently unchanged egg white.

Other foreign substances which may enter the milk include certain drugs, and after heavy smoking, nicotine may be demonstrated in the purified extracts of human milk. The fact that the intake of food, drugs and vitamins influences the composition of breast milk suggests that the milk supplied by certain mothers may be inferior in quality to that supplied by others. In the future, therefore, special attention may be paid to supervising the mother's diet to favor the production of the best attainable quality of breast milk.

In this manner breast milk may be changed and improved occasionally to some extent. "Styles" in breast milk, however, will never undergo the changes and modifications such as have been required to render cow's milk suitable for infant feeding. Throughout all time, the product of the human breast will reign supreme among foods in reducing infant mortality and in supplying all the requirements for perfect nutrition of the body.

From Richard A. Bolt, M.D., Cleveland, Ohio:

The purpose of the mammary gland is to nourish the young of the species. If we judge from the cumulative evidence of more than a million years, it has served that purpose admirably. Man, the highest of the mammals, has been well nourished thus, and it is questionable if he could have survived in the early ages without breast feeding.

It is admitted generally that the greatest single factor in preserving infant life has been breast feeding. Every comprehensive study of infant mortality has added emphasis to the fact that the breast fed baby stands a much better chance of surviving than the one fed artificially. Breast feeding not only nourished the baby, but caused the mother to become domesticated. This domestication of the mother has been the most potent factor in establishing the family and the home, where the rearing of children is most successful.

It is recognized, of course, that factors other than breast feeding may turn the tide in infant life. The intelligence of the mother, her social and economic status, and the sanitary conditions under which she brings up the family—all have a direct bearing upon the infant's welfare. Even under the worst conditions, children may be reared successfully by means of breast feeding when it would be impossible any other way.

However ultra-modern we may be, there is no escaping the fact that the function of bearing children remains with woman, and that a very delicate biochemical balance is established between child-bearing and lactation. Breast feeding is the natural, normal and safest method by which a child can be fed.

A SILVER LINING TO THE CLOUD OF DEPRESSION

It is significant that during periods of economic depression the infant mortality rate usually falls. This appears to be closely related to the unemployment of women outside the home. Holt pointed out this situation years ago and

instanced the Lancashire district of England during the Civil War. The depression there was marked by an increase in general mortality but a sharp decline in the infant mortality. Holt states, "Opportunities for outside work being shut off, women could not go out to work and were compelled to stay at home and so nurse their children." *

During the present depression there has been very little, if any, increase in the crude death rates. On the other hand, there has been a decided decline in infant mortality. It must be remembered always that breast feeding is intimately related to other factors in the care of the infant. The intelligent and careful supervision of the mother is a great factor in addition to breast feeding.

Babies undoubtedly do best upon the breast milk of their own mothers. Numerous studies have revealed that the milk from different animals varies in composition, undoubtedly to meet the special needs of each particular species. Man is no exception to this provision of nature. It is possible, however, to so modify the milk of other mammals as to make it acceptable to the human infant and, under proper conditions, the infant will thrive. The question arises as to whether it is possible to adapt the milk of one species to meet the complete nutritive requirements of another. While we have made great progress in the reconstitution of milk to adapt it to the infant's needs, it can still be said that no modification yet devised has given the complete satisfaction and met all the requirements of the growing child as does its mother's milk.

MANY FACTORS IN THE SITUATION

The superiority of breast feeding over any other form, in the early months of life, has been proved amply by many studies. Repeatedly statistics have revealed that under similar conditions babies on the breast are more likely to survive than those given artificial feeding in the early months of life. In comparing the two forms of feeding, the figures must be viewed with caution, for the social, economic, and sanitary conditions, as well as the intelligence of the mothers, have a great deal to do with the success of artificial feeding.

After the first few months of life, under ideal conditions, it is possible so to feed the baby with modified mixtures as to suit its nutritive needs. Faber and Sutton recently have studied breast feeding and bottle feeding in the San Francisco Bay Region. They state that while breast feeding gives better results in the first three months of life, the artificially fed infants show a greater mean rate of gain after that time. As a matter of fact, the artificially fed babies appeared to do better after the first quarter and were freer from certain infections. In other parts of the country where the racial composition is not the same and the age distribution of the mothers differs, comparison with the babies of San Francisco mothers must be made with reservation.

It is admitted that among the more prosperous classes, in a highly developed society, breast feeding becomes more and more difficult. Part of this is due to the conflicting interests, social and economic, outside of the home. The routine of breast feeding becomes monotonous; it lacks the excitement of social or political activities. The mother becomes increasingly high strung and excitable. Under such conditions breast feeding is not attempted or is given up after a brief trial.

Many of the medical profession cater to the modern woman, assuring her that satisfactory artificial feeding can be arranged. Fortunately for the baby, there are scientific methods of modifying cow's milk which, when carried out under ideal conditions, are relatively satisfactory, and with the added protection of pasteurization the danger of gastro-intestinal disease is reduced considerably.

* Curiously enough, in this depression, some cities report more women employed than men. It is too soon, however, to note the ultimate effect on either the birth rate or the infant mortality rate in these cities.—*Editorial note.*

UNSURPASSED ADVANTAGES OF BREAST MILK

But with the mothers of the great middle class, and more especially those of the poor, breast feeding is a boon for mother and baby alike. It has a number of advantages which should be stressed. These have been set forth by many authorities on infant feeding, and have been well summarized by McLean and Fales as follows:

1. *Cleanliness:* Breast feeding involves no handling of the milk and hence avoids contamination.

2. *Composition:* There is a growing belief that for successful nutrition all feedings for infants should approach the concentration of human milk. . . . Normal woman's milk contains the biological factors necessary for human growth and well being.

3. *Convenience:* The food supply is at hand when needed. No modification is necessary. No adjustment of temperature need be made and no storage facilities need be provided.

4. *Temperature:* The temperature of the food is that of the body of the infant.

5. *Immunity:* Certain anti-bodies and ferments are probably transmitted from the mother to the infant in the milk. . . . These ferments and anti-bodies are protected from such deterioration as might take place through mechanical and chemical changes induced by handling or storage.

6. *Supply:* Supply is usually regulated by the demand.

In addition to all these physical factors there are subtle influences on growth and development which come through "mothering," and these are promoted best by systematic breast feeding.

Renewed interest has been focused on the chemistry of breast milk as it relates to the nutritional well-being of the baby at the breast. Under standardized methods of collection and analysis, gross chemical changes in breast milk representative of the first and last halves of nursing have been observed. These changes were not influenced by the presence and condition of the baby at the breast. They are indicative of nutritional and clinical significance. During the progression of nursing, the fat, protein, casein-nitrogen, total solids and phosphorus tend to increase. It has been pointed out that definite ratios between various constituents in the milk are of importance. These ratios, with the progression of nursing, may approach abnormal values in some cases. Furthermore, the inconstancy of ratios between certain constituents lends support to the indications that certain components are controlled by different secretory mechanisms.

"*Human Milk Studies—VII. Chemical Analysis of Milk Representative of the Entire First and Last Halves of the Nursing Period.*" Icie G. Macy, Betty Nims, Minerva Brown, and Helen A. Hunscher. *American Journal of Diseases of Children*, Sept., 1931.

Hoeffer and Hardy studied the effect of breast and artificial feeding upon the later physical and mental development of human infants. Three hundred and eighty-three public school children in Joliet, Illinois, were investigated. The children ranged in age from seven to thirteen years. The results with regard to physical condition showed that the children who had been fed artificially ranked below all of the breast fed group, and that those breast fed from four to nine months ranked highest. There were no tall children among the artificially fed; and there were on the average fewer overweights, more underweights, fewer above the average in muscle tone, more below the average, a lower index of nutrition and a later age of walking in the artificially fed group than in any or the groups of the breast fed infants. Analysis of the children classified by the physician as being in good condition at the time of the medical examinations shows that a smaller percentage had been artificially fed than had been breast fed for at least four to nine months.

S. Maurer and M. Th. Hanke in *Illinois Health Quarterly*, September, 1931.

Public Health Nurses in China Today*

By S. M. WOO, M.D.
Director, Bureau of Health—Ministry of Railways, China

EVERY public health nurse should be, and generally is, well versed in the science and art of public health nursing. There is no need, therefore, of entering upon those aspects of the work, which are already well known to her. But to know the principles and practice of public health nursing is one thing; to apply them, so that they will be welcomed by the people and render real service, is quite another matter. The former may be learned in the school, the latter must be learned through prolonged contact with the people.

Assuming that many of the young public health nurses have not been out of school very long, and therefore are not well acquainted with the social conditions of China, it may be advisable to point out a few of the facts, the knowledge of which will help them to get a better understanding of the problems and difficulties which they are bound to meet sooner or later, and thus arm them, so to speak, against the hard task before them. The following outstanding facts may be mentioned.

1. The vast majority of the Chinese people know little or nothing about the purpose and nature of public health nursing. Most of them do not believe in modern curative medicine, which has had about a hundred years of history in China. If the people do not have any faith in modern curative medicine, with a fairly long history behind it, at the time of their sickness and pain, how can one expect them to give much support to public health nursing, which has scarcely begun its career, when the people are well and feel no need of any help?

2. Owing to repeated civil wars, banditry, famine and general business depression, the people of China have been reduced to extreme poverty. Under such circumstance, it is impossible either for the government, or the individuals, to finance any public health movement in an adequate manner, even if they thoroughly believed in it.

3. There are so many major national problems pressing for solution, such as suppression of communists, militarists, and bandits, the development of basic national industries, the building of railways, the conservancy of waterways, the reforestation of vast areas, the reform of national finance, education, etc., the abolishing of extraterritoriality, the reclaiming of millions of square miles of waste lands, the suppression of opium smoking, the disbandment of superfluous soldiers, etc.,—all these absorb the attention of the national leaders. Is there any wonder, if they consider public health nursing as a matter of secondary importance and subordinate it to other seemingly more vital claims?

4. Having to struggle hard just to keep the body and soul together, the vast majority of the Chinese people pay no attention to anything which is not urgent. They take no interest in anything which has not the most obvious and immediate value to themselves. They just do not want to be bothered by strangers with strange propositions.

5. The average Chinese have no faith in people whom they do not know. A stranger is generally regarded as a doubtful character, if not a dangerous one. "I do not know you" is another way of saying "You mean nothing to me, go away!"

* Quoted from *The Nursing Journal of China*, October, 1931. This article offered such sensible advice to any public health nurse working under adverse conditions that we could not resist reprinting it almost without change.

While making a house-to-house survey in Woosung, the police, who escorted me, said to every housewife we came to, " Please don't be afraid—he is not a bad man!"

6. The social conditions and the psychology of the Chinese Nation are so different from those of the West, that any attempt to make a direct application of western methods, without the necessary modification, is bound to fail.

These facts—the ignorance of the people regarding public health nursing, the financial stress of the present, the far more urgent claims of great national problems pressing for solution, the indifference of the people towards problems which, in their opinion, are not particularly urgent, the coldness and suspicion of the mass toward all social workers who have not yet gained their confidence, and the difficulty of applying an art and science developed in the West to meet Chinese needs—all these make it absolutely necessary for all public health nurses to adopt very special policies and attitudes towards their work as well as towards the people whom they seek to serve. If the readers read the above with proper understanding, it will have become obvious to them that the task before the public health nurse is by no means an easy one. Therefore the public health nurses should not cherish any extravagant hopes. On the contrary, they should expect to meet with lack of appreciation, irritating remarks, coldness and indifference or even contempt, little or no financial support, inadequate remuneration, doubt over their sincerity and good will, and the hopelessness of bettering the conditions of the people within a short time.

Such hard facts will drive many to despair. But with courage, faith, humility, patience, persistence, unconquerable good will and a charitable spirit, all the obstacles may be overcome. It is these qualities which made Florence Nightingale one of the greatest women in history. What Florence Nightingale has done, any public health nurse can do, if she is willing to pay the price. Right spirit and proper attitudes, then, are the first and most important conditions of success.

Secondly, begin small. It is much easier to succeed in small adventures than in big ones; and nothing succeeds like success. Therefore, do not attempt too much. Do not try to help four hundred million people at once. It cannot be done. Do one thing at a time. If success is achieved in one adventure, confidence is thereby gained. With the confidence of the people it will be an easy matter to expand the work.

Thirdly, do first things first. Start by helping the people in meeting their most urgent needs. Do not start by asking them embarrassing questions in order to secure materials for statistics. The average Chinese cannot see any earthly use in that; many of them positively resent your inquisitiveness and most of them will not tell you the true facts. Start by helping the mothers take care of their beloved babies, especially when the latter are sick. They appreciate that. Teach them how to avoid the diseases which they most dread,—meningitis and cholera for instance. Show them how to nurse their loved ones in the sick-bed, when they do not know what to do. Advise the poor how to get the most nutrition with the least expenditure of money and energy. They will be interested and flock to you for advice, after they have found it has worked well with their friends. These are only a few of the things which may be done with profit. A public health nurse with good common-sense will find out for herself many other things which she can do with satisfaction both to herself and to the people whom she serves.

Be not over familiar with people before you have gained their confidence. Get a proper introduction, if possible, before you call on any new home. Never assume an air of superiority—this will be discovered and justly resented.

Public health nurses should make first-hand observation of the conditions of the place where they are to begin their work. They must also try hard to understand the people among whom they must do their work. Only thus will they be able to adopt the most suitable and practical measures, which are so vital to the work.

It is not the purpose of this article to tell the public health nurses in detail what they should do and how to do it—they know that better than the writer. The purpose of this article is simply to keep them from the common fault of taking things for granted and to initiate them in the habit of unbiased observation and original thinking. If the writer can succeed in that to some extent, this article will not have been written in vain.

VIRGINIA OBJECTIVES FOR CHILDHOOD.

The Health and Medical Service Committee, Dr. W. F. Draper, Chairman, at the Governor's Conference on Childhood and Youth, held in Richmond, Virginia, November 24, 1931, agreed upon the following objectives:

1. That every expectant mother, regardless of circumstances, shall consult a physician for health supervision as soon as she suspects her pregnancy, and again in six weeks after delivery.
2. That every child shall be under the care and health supervision of a physician from the date of his birth.
3. That a sufficient number of hospital beds be available for indigent women who are seriously ill during pregnancy, labor, or as a result of labor, and also for indigent children needing special treatment.
4. That the laity be made to realize the importance of health supervision for themselves and their families, and become willing to pay for advice for the prevention of disease rather than for a prescription or for medicine; and that every practicing physician in the State be brought to realize his responsibility for health supervision as well as for curative measures.
5. That every child in the State be under the supervision of a full-time health worker whose duty it is to promote and correlate the above objectives.

If Once You Have Slept on an Island

By REBECCA M. DOUGLAS

Delano Nursing Service, American Red Cross and
Maine Sea Coast Mission Society

THE qualifications most needed by a public health nurse on the islands off the coast of Maine are of course a knowledge of nursing, ability to adapt to all sorts of conditions and hardships, and a sense of humor. With these three qualifications—and a lot of warm clothes—the nurse perhaps will be able to hold her job. What is *not* needed by an island nurse is too much unapplied "theory"—telling people to wash their hands in running water, for instance, when the only running water they have is in a brook, and the brook quite far away; telling them that the kitchen is a food laboratory when in reality the kitchen is the dining room, living room, laundry, and, on Saturday nights, the bathroom. In so severe a climate, with no furnaces, it is easy to see why this is so.

Matinicus is the outer-most of the islands, where, because of the distance from the mainland—twenty miles away—the Delano nurse makes her headquarters in winter. We have only two mail boats a week, and on account of the very high winter sea, it is often impossible to bring a doctor out. One of the fishermen on being asked by a stranger, "What in the world do you do without a doctor in case of severe illness?" replied "Oh, on this island we just let people die a *natural* death."

One of the nurse's difficulties is to make the island people understand that she cannot diagnose. The Knox County Medical Society kindly gave the Delano nurse standing orders to the effect that they (the Society) "approve any action the nurse on Matinicus may deem necessary to relieve suffering, insofar as she knows how." This permission is of course very comforting to the nurse as there are times when she is obliged to carry on "insofar as she knows how." One night last fall, a man on one of the outer islands had a severe heart attack. There was a raging sea. The nurse knew had she asked any of the fishermen on the island to go for a doctor, they would not have hesitated—they are like that—but she also knew that it perhaps would mean the loss of two lives in the effort to save one. She did for the patient what she thought a doctor would have ordered done, and

had the satisfaction of seeing her patient improve under the treatment she administered. We are, in truth, a law unto ourselves because of our enforced isolation.

The Red Cross and the Maine Seacoast Mission are affiliated in this work. The Mission boat, the "Sunbeam," takes the nurse from one island to another. Sometimes this is a very difficult task. Very often at high tide, the "Sunbeam" has to anchor quite far out from shore, and one must be taken to land in a small rowboat, and either climb an icy ladder up to the dock or walk over slippery seaweed. Many times in climbing the ladder one feels as if she just cannot make it, but before one really falls into the sea someone yells "Hurry up there, don't take all day," and she raises her half-dead self "to higher things" by means of the icy ladder rounds.

In the summer, of course, it is different. One wonders how it *can* look so different in such a few months, for everywhere along the coast of Maine there is beauty. During June and July the Delano nurse does the health work in the Maine Seacoast Mission Vacation Bible School. She teaches that cleanliness is next to godliness—that, in fact, it is godliness. Though she has never had the courage to tell the Bible School that had Job not slept in the ashes he would not have had boils, yet she can teach that Moses was a great public health leader.

Though the work is often discouraging, it is never dull. The people are very appreciative and there is a spirit of neighborliness and goodwill which one does not always find in the city. Wherever the Delano nurse has carried on home hygiene classes, the women have shown much interest, some of them not missing a single lesson. Of course, there are always prenatal and confinement work, and times when no doctor is present at confinement—a hard position for the nurse. The people often say to her, "It is only natural for women to have babies." They do not realize the high maternal mortality in the country. The nurse feels that should anything go wrong on a delivery she would feel worse over that than over disastrous outcome in illness.

The fishermen always are having infected hands and arms, especially the wrists. The stiff oilcoat cuff rubbing against the wrist is apt to cause an abrasion of the skin, dirt gets in, and infection follows. Then there are minor accidents, such as sprained ankles and cuts from knives when dressing the fish. All these are brought to the attention of the nurse. After one has worked on an island one feels that any other work would be rather tame in contrast.

If once you have slept on an Island
You'll never be quite the same.
You may look as you looked the day before,
And go by the same old name.
You may bustle about in street and shop,
You may sit at home and sew—
But you'll see blue water and whirling gulls
Wherever you may go.

You may chat with your neighbors of this and that,
And close to your fire keep—
But you'll hear ship's whistle and lighthouse bell
And tides beat, through your sleep.
Oh, you won't know why, and you can't see how
Such change upon you came—
But—once you have slept on an island
You'll never be quite the same!

The Three Million

By ENA G. MACNUTT

Special Teacher for the Hard of Hearing, Public Schools of Newton, Massachusetts *

THREE million, that is what they say—three million hard of hearing children in our public schools, and "they" are men who have made thorough investigation and make the statement with authority.

Where are the three million, you ask. Everywhere. In your community and in mine. Rare indeed is the community without them.

We are not referring to the deaf child who has never heard, or has lost all his hearing through illness. He is usually adequately cared for by the schools for the deaf. The three million are the hard of hearing children—those who have some hearing loss, but in most cases have sufficient hearing remaining to keep pace with their classmates, granted the necessary training; and those whose hearing can be restored if the loss is detected before it is too late. In many of these cases nobody realizes what the trouble is. Frequently the child himself does not realize. He may know that he is slower than his fellows in grasping what is said in the classroom, but takes it for granted that they are "smarter" than he. His parents and teachers may notice that he is not as keen as his mates, but call it inattention.

There is another group who know that they are hard of hearing, but suffer themselves to be called dull and stupid rather than admit the defect. These are often aided and abetted by parents who regard deafness as a mental rather than a physical defect, something to be ashamed of and concealed. There is no doubt that many cases of deafness, curable if treated in time, have become chronic through neglect.

There is still a third group whose hearing loss is so great as to be very noticeable. These children lag in their school work, are often the despair of teachers because of their idle and mischievous ways, and are general misfits in the classroom.

Unmistakably we have these children with us. As nobody seemed to have the answer to their problems, those who from their own experience as hard of hearing children knew this situation, did what no other group of handicapped people have done—banded together to solve their own problems.

The first league for the hard of hearing, founded in 1910, was soon followed by others in all the principal cities of our country, until today they number well over one hundred. In 1919 these leagues united to form the American Federation of Organizations for the Hard of Hearing, and to take up in a larger way the crusade for the welfare of the hard of hearing child and adult.

This organization, having gained the coöperation of the Bell Telephone Company, and having called attention to the inadequacy of the hearing tests given in the public schools, appealed to the company to devise a method of group testing. As a result we have the 4-A or phone-audiometer, with which forty children can be tested at one time. Most of those who have normal hearing are eliminated on the first test. Those who do not pass are given a second, and in some cases a third test, which frees still more from suspicion. We then have left a group which quite evidently have some ear trouble. Sometimes this group includes ten per cent or more of the school population, in other cases as low as 1 per cent, de-

* Miss Macnutt is also chairman of the Teachers Committee, American Federation of Organizations for the Hard of Hearing.

pending upon the type of home and the amount of medical care the children have received.

HELPING THE RURAL CHILD

The purchase of a 4-A audiometer is a simple matter for a large city, but the budget in smaller communities may not warrant this expenditure. How can the smaller places secure this means of testing their children?

Just as small towns combine in employing a music supervisor, drawing supervisor, school nurse, or school superintendent, they can share in the purchase and use of an audiometer. Some leagues for the hard of hearing own audiometers and loan them for testing. The American Federation of Organizations for the Hard of Hearing is glad at all times to furnish information as to the nearest source of help in the work for the hard of hearing.*

Having found the hard of hearing child, we should, first of all, have him examined at an ear clinic, or by an ear specialist and get the diagnosis and prognosis of his case. Here again the rural districts are at a disadvantage, but some towns have children with defective teeth taken by the school bus to a dental clinic or a dentist in an adjoining town or city, and the same arrangement can be made for taking the children with defective hearing to an ear clinic or an otologist.

When we have the diagnosis and prognosis, we shall find our children separated into two groups, those who can, in all probability, be cured by treatment or operation and saved from adult deafness, and those for whom deafness seems inevitable. With the former group lies a large field of opportunity for the school nurse. More than one child, who a short time ago was hard of hearing, owes his normal hearing of today to the school nurse who tactfully brought the parents to see their child's needs and secured treatment for him.

Many of the second group will need treatment to prevent their deafness from increasing, and they will need lip reading also. Through a mastery of lip reading the hard of hearing child may continue his education with his classmates of normal hearing and retain his place in the business and social world after leaving school. The school years are the most impressionable years, the years when learning comes easiest and when good adjustment to the type of defect which makes itself felt in every waking hour can best be made. Lip reading taught to the child with a poor hearing prognosis may save him from a long period of rehabilitation in his adult life.

Many cities now employ an itinerant teacher of lip reading. Here again the rural districts have their special problem, but it can be solved. Several towns can employ the same lip reading teacher in the way suggested for the purchase of an audiometer. If a school is too isolated to be reached in this way, a teacher in that school may be trained as a teacher of lip reading and take over that work with the small group that would be found in one school. The teaching of lip reading requires special training, however, and should not be attempted without it. A six weeks' summer course is offered now by a number of private schools and universities, with very little expense involved.

Let us now go back to the very hard of hearing child, whose hearing loss is so great that he gets practically nothing from the work in the classroom. If his speech is defective, he should be placed in a school for the deaf, for a time at least, to overcome this difficulty. If he is a child of good mentality, whose speech is not affected by his deafness, and the coöperation and help of intelligent parents can be secured, he may, with the aid of lip reading, continue in the public schools. Very hard of hearing children have been able to do this, and it seems to be the wisest course wherever it is possible without too great nerve strain for the child.

*** An inquiry addressed to Miss Betty C. Wright, Assistant Director, 1537 35th Street, Washington, D. C., will receive prompt attention.**

The school nurse should endeavor to have the hard of hearing child detected in her community by enlisting the aid of Parent-Teacher Associations or other organizations to secure the treatment and instruction that he needs; by learning more about deafness, its causes and effects, passing this information on to the parents and keeping a close watch on those children who are the victims of contagious diseases. Thus she may aid in the prevention of deafness and add to the effectiveness of her work for the community and for the individual handicapped youngster.

A Pellagra Clinic*

By MARGARET HARRY

County Nurse, Oconee County Health Department, Walhalla, S. C.

THE problem of pellagra in Oconee County, South Carolina, is one of considerable magnitude. Both natural resources for prevention and clinics are available, however, and we hope to be able to reach the roots of our problem. Oconee County is the western-most tip of the State. A portion of its mountainous region is included in the Nantahala National Forest. The land area is 650 square miles, with a population of 33,000 persons. There is abundant water power making possible the operation of five cotton mills in the county. The soil is rich and the crops are varied. The county produces some of the finest apples in the State. We have found pellagra to be a county-wide disease.

A pellagra clinic was held at the County Health Department in August, 1931, by Dr. James A. Hayne of the South Carolina Board of Health, and Dr. C. V. Akin of the United States Public Health Service. Sixty-five pellagrans attended this clinic, farm tenants and textile workers making up the larger portion of this number. Grouping these cases according to age, the highest per cent fell between the age of thirty and forty years or at the peak of their earning power. The youngest was a child of five years while the oldest was a woman of sixty-five.

Among the clinic findings it was ascertained that many of these patients were subject to recurring flare-ups of pellagra, and that the lives of children and adults were jeopardized through neglect of health measures. All of these clinic cases had suffered for a number of months, some for several years. Others throughout the county were receiving no treatment whatever, or such irregular treatment as to be almost ineffective. Those treated by local physicians obtained desirable results for the period of time that they were being treated, but in many chronic cases the doctor was unable to effect a cure because of long intervals when the patients dropped away from care and were without further treatment or observation. Drifting into this state of neglect, patients, unable to provide a proper diet for themselves, fail to see the results from medical care for which they had hoped, and lose faith in their physicians.

Without this clinic, many patients would not have come under medical supervision until late in the course of their illness, nor would they have been followed up and the trend of their disease noted. Patients were urged to keep under observation until a complete recovery was brought about, and were given educational literature on pellagra and specifically advised as to diet and hygienic living.

* The Journal of the South Carolina Medical Association has published a similar report of this clinic.

The sale of brewer's yeast by our County Health Department furnished additional means for finding pellagra patients. The increased amount of yeast advised by local physicians to pellagrans has added to the number of office contacts. Even more cases would come to our office, if it were not that a grocery store in the county also handles brewer's yeast. The yeast is given free by our County Health Department to extreme cases of poverty, and sold to all who can pay for it. A careful record of every pellagran contacted is kept in the local Health Department. Other new and old cases are reached for the clinic through posters, press publicity, personal interviews, and letters. The coöperative interest of the local physicians of the county was shown through the number of cases that they referred to clinic, and through the visits to clinic of five physicians and one medical student.

We are not yet in control of the pellagra problem in this county, but it is being handled in a constructive manner. If our hopes are to be fully realized, both preventive and curative medicine must give more than a passing thought to the problem. The good results of pellagra clinics are sufficiently definite to place an added obligation on the help of the United States Public Health Service in the matter of examining and advising pellagrans. We feel that the favorable reaction and response of the people to pellagra clinics has been convincingly demonstrated.

A family with pellagra, and their home

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

THE FIRST TWENTY-FIVE PER CENT

After little more than two months of enrollment activity, the N.O.P.H.N. National Membership Committee is able to announce as this is written early in December, that applications and pledges for membership have been received in sufficient number to increase the October enrollment of the National Organization by more than twenty-five per cent. This, in the estimation of the committee, is an excellent, not to say a magnificent, showing. It is all the more outstanding because many of the state and district committee chairmen have found it necessary to delay their intensive enrollment period until after January first due to local community chest drives.

This figure, twenty-five per cent, represents well over a thousand applications, and has been made possible not only through the activity of the members of the various committees, but also through the coöperation of many individual nurses and interested laymen throughout the country. Nurse executives from many agencies have volunteered to give talks on membership at meetings of their own groups, and have promised to enroll their boards after enlisting their staffs.

In more than forty states committees are now actively engaged in carrying on the work of the campaign. In nearly every instance the vice-chairman of the state committee is a lay person who has undertaken to secure additional members from this group. The support of so many lay people should result in an active interest in public health nursing and a realization of its importance which will greatly strengthen the program.

In Indiana an issue of the State Health Bulletin, "Echoes" was published which was devoted entirely to the N.O.P.H.N. Special Membership Enrollment. In Iowa the enrollment was featured on the front page of the Health Bulletin and a list of public health nurses in the state was printed. An application blank was included in both publications.

The N.O.P.H.N. has just revised the booklet which describes in detail many of the services which are rendered by the organization. A copy of this booklet will be made available to every member.

BRATTLEBORO STUDY

At the request of the Committee on the Costs of Medical Care, the N.O.P.H.N. participated in a study of the nursing and other medical activities of the Thompson Trust in Brattleboro, Vermont. The study of the nursing program was of particular interest because of the part which the training of attendants and the administration of this service plays in the whole program of the Mutual Aid Association. The objective of the nursing study was the evaluation of the nursing program in terms of the needs of Brattleboro and its relation to the general problems of nursing.

STATE SOCIAL HYGIENE INSTITUTES

A new arrangement for the social hygiene institutes was tried in November in New York State. Through the State Department of Health, three institutes of two days each were arranged in Albany, Syracuse and Buffalo. At each institute a welcoming address was given by the local health officer, the purpose of the institute explained by the state director of the division of public health nursing or her representative, and the integration of social hygiene in a generalized nursing program given by Miss Moore

of the N.O.P.H.N. Other sessions included speeches by other members of the State Department: the Divisions of Social Hygiene and Mental Hygiene, and local authorities on the public health aspects of social hygiene. In all, about 200 nurses attended these institutes.

SURVEY OF ADMINISTRATION AND PRACTICE OF PUBLIC HEALTH NURSING

Wide interest is being shown in the N.O.P.H.N. survey, made possible through the Commonwealth Fund, with Newark, N. J., as first "stop," in December. Enthusiastic response has been received by the N.O.P.H.N. from those local agencies invited to participate in the survey. The list of communities in which every agency employing public health nursing has agreed to be studied includes:

Birmingham, Ala.
Burlington, Vt.
Carthage, Mo.
Charleston, W. Va.
Cleveland, O.
East Mauch Chunk, Pa.
Guilford, Conn.
Jefferson County, Ala.
Lawrence, Mass.
Lowell, Mass.
Milwaukee, Wis.
Montclair, N. J.
Newark, N. J.
Richmond, Va.
St. Louis County, Minn.
San Antonio, Texas
San Francisco, Cal.
San Joaquin County, Cal.
Terre Haute, Ind.
Tonawanda, N. Y.
Topeka, Kansas
Wilkes-Barre, Pa.

PRELIMINARY PROGRAM—JOINT SESSIONS OF THE BIENNIAL CONVENTION

Monday Evening, April 11th

Joint Opening Session
Addresses of Welcome
Greetings from the American Red Cross
Key-notes of Progress in Nursing by the Presidents of the three national organizations

Tuesday, April 12th

9–10:45 Subject: *Nursing at the Cross-Roads*
A. Implications for nursing in the findings of two five-year studies
The Costs of Medical Care Committee
The Grading Committee
B. Significant Adjustments in Nursing Service
C. Partnership with the Public

Wednesday, April 13th

9–10:45 Subject: *Next Steps for Nursing*
A. How shall we select and prepare the undergraduate nurse?
B. How shall we select and prepare the graduate nurse?
C. How shall we distribute nursing service equitably?

2:30–4:45 Subject: *Mental Hygiene through the Profession*
A. The Growth of Mental Hygiene
B. A Mental Hygiene Point of View in Nursing
C. Attempting an Application in the Various Fields of Nursing

Evening Subject: *The Present Economic Situation*

TRANSPORTATION FOR THE BIENNIAL CONVENTION

Mrs. Alma H. Scott, Chairman of Transportation for the Convention of the three national nursing organizations, to be held in San Antonio, Texas, April 11–15, 1932, has received word that the following state chairmen of transportation have been appointed to date:

NORTH ATLANTIC STATES

New York	Emily J. Hicks, *Chairman*, 450 Seventh Ave., New York City
Connecticut	Margaret K. Stack, 175 Broad St., Hartford
Delaware	Mary A. Moran, 1313 Clayton St., Wilmington
District of Columbia	Bertha E. McAfee, 1746 K St., N. W., Washington
Maryland	Sarah F. Martin, 1211 Cathedral St., Baltimore
New Jersey	Arabella Creech, 42 Bleecker St., Newark
North Carolina	E. A. Kelly, Highsmith Hospital, Fayetteville
Pennsylvania	Esther Entriken, 400 N. 3rd St., Harrisburg
Virginia	Emma C. Harlan, 203 Ridge St., Charlottesville
West Virginia	May Maloney, Cook Hospital, Fairmont

NORTH CENTRAL STATES

Illinois	Gladys Sellew, *Chairman*, 509 S. Honore St., Chicago
South Dakota	Agnes B. Thompson, Madison
Ohio	Mrs. E. P. August, 85 E. Gay St., Columbus
Wisconsin	Mrs. C. D. Partridge, 527 Layton Ave., Cudahy
Indiana	Flora A. Dutcher, 1217 Meyer Kiser Bk. Bldg., Indianapolis
Iowa	Stella S. Scott, West Lawn, Iowa City
Michigan	Olive Sewell, Capitol Savings & Loan Bldg., Lansing
Minnesota	Caroline Rankiellour, 2642 University Ave., St. Paul
Nebraska	Gertrude Krausnick, 1023 Sharp Bldg., Lincoln
North Dakota	Mathilda P. Paul, 1022 First St., N. E., Minot

SOUTH CENTRAL STATES

Missouri	Elizabeth Martin, *Chairman*, 425 E. 62nd St., Kansas City
"	Ella Wier, 2221 Francis St., St. Joseph
"	Mrs. Zola Lunbeck, 4343 Oak St., Kansas City
"	Mrs. Clara P. Holmes, 4560 Gibson Ave., St. Louis
Kansas	Cora A. Miller, 1012 Chestnut St., Emporia
Oklahoma	Mrs. Ada B. Godfrey, 1740 S. Wheeling, Tulsa

Headquarters of the three national associations have been notified that reduced rates will be granted over all the principal routes in the United States on the Identification Certificate Plan. Under this arrangement, those going to the convention will secure a certificate from (a) the Section Chairman of Transportation for the state; or (b) the Executive or Elected or General State Secretary; or (c) the State Supervisor of Public Health Nursing; or (d) if preferred, from Mr. F. M. Adams, City Passenger Agent, Baltimore and Ohio Railroad, 122 East 42nd Street, New York, N. Y.

The following Passenger Associations have authorized the sale of tickets on the basis of one and one-half current one-way fares (with minimum excursion fare of $1.00 for the round trip) upon presentation of identification certificates which will be available to members of the three national nursing organizations and dependent members of their families; the dates of sale as shown below, limited to thirty days in addition to date of sale. All one will need to do in San Antonio will be to have the return ticket stamped in that city. Space will be set aside for this purpose (place to be named later) in order to make this necessary stamping of tickets as simple a matter as possible.

Tickets may be routed in two ways: (a) via the same route in both directions, at one and one-half fare; and (b) via any authorized route in one direction and via any other authorized route in the reverse direction at reduced fares.* Information as to the amount of this reduction where diverse routes are desired, is to be secured from the local ticket agent when the nurse purchases her ticket.

* There are additional concessions of interest to those planning to take vacations after convention. In former years the return trip on special rate tickets had to be made a few days after the convention closed, and could be made at reduced rates only if returning by same route.

The Trans-Continental Passenger Association and Western Passenger Association

Territory		*Dates of Sale*
Arizona	Missouri	Opening: April 8
Colorado	New Mexico	Closing: April 14
Illinois	Utah	
Kansas		

Territory		*Dates of Sale*
Iowa	North Michigan	Opening: April 7 Closing: April 13
Manitoba†	North Dakota	
Minnesota	South Dakota	
Montana	Wisconsin	
Nebraska	Wyoming	
British Columbia	Nevada	Opening: April 5 Closing: April 12
California	Oregon	
Idaho	Washington	

† Manitoba (on Great Northern, Northern Pacific and M., St. P. and S. S. M. Railways, also from Winnipeg via Canadian National and Canadian Pacific Railways).

Trunk Line Association

Territory	*Dates of Sale*
New York State (east of Buffalo and Salamanca) New Jersey Pennsylvania (east of Erie, Oil City and Pittsburgh) Delaware Maryland District of Columbia Virginia West Virginia (east of Wheeling, Parkersburg and Kenova)	Opening: April 8 Closing: April 14
From New York, N. Y., via Mallory Steamship Line and Southern Pacific Steamship Line	Opening: April 2

Southwestern Passenger Association

Territory		*Dates of Sale*
Arkansas	Kansas	Opening: April 8 Closing: April 14
Louisiana	Missouri	
Oklahoma	Texas	
Memphis, Tennessee	Natchez, Miss.	
Vicksburg, Mississippi		

It would be advisable for nurses in these southern states and cities to note that the following Southwestern Lines are not granting reduced excursion fares: Arkansas and Louisiana Missouri Railway; Fort Smith and Western Railway; Graysonia, Nashville and Ashdown Railroad; Kansas, Oklahoma and Gulf Railway; Midland Valley Railroad; Missouri and North Arkansas Railway; National Railways of Mexico; Oklahoma City-Ada-Atoka Railway; and the Wichita Falls and Southern Railway.

Southeastern Passenger Association

Tickets will be sold April 8–14. Diverse route fares will also be authorized on special basis except that no diverse routes will apply south of Jacksonville, Florida, or between the A.C.L. Railroad and the S.A.L. Railway through the Virginia gateways.

New England Passenger Association

Territory	*Dates of Sale*
Boston and Albany Railroad Boston and Maine Railroad Canadian Pacific Railway (Maine and Vermont) Central Vermont Railway Eastern Steamship Lines (New York, N. Y., and east) Grand Trunk Railway System (Maine, New Hampshire and Vermont) Maine Central Railroad Narragansett Pier Railroad New England Steamship Company New York, New Haven and Hartford Railroad Rutland Railroad	Opening: April 8 Closing: April 14

Central Passenger Association

Tickets will be sold April 8–14 from Central Passenger Association territory.

FARES TO SAN ANTONIO

Going and returning via same route

From	One-way rail fare	Fare and one-half	One-way lower berth	One-way upper berth
Atlanta, Ga.	$38.73	$58.10	$12.00	$ 9.60
Baltimore, Md.	60.73	91.10	18.00	14.40
Boston, Mass.	74.66	111.99	22.50	18.00
Buffalo, New York	57.48	86.22	18.38	14.70
Chicago, Ill.	43.73	65.60	13.50	10.80
Cincinnati, O.	43.52	65.28	14.63	11.70
Cleveland, O.	52.42	78.63	13.50	13.20
Denver, Col.	38.95	58.43	12.75	10.20
Detroit, Mich.	51.08	76.62	15.38	12.30
Kansas City, Mo.	27.93	41.90	9.00	7.20
Los Angeles, Cal.	51.70	77.55	15.38	12.30
Milwaukee, Wis.	46.79	70.19	16.50	13.20
Minneapolis, Minn.	45.61	68.42	14.63	11.70
Montreal, Que.	70.48	105.72	25.50	20.40
New Orleans, La.	21.24	31.86	6.38	5.10
New York, N. Y.	67.43	101.15	21.00	16.80
Philadelphia, Pa.	64.83	97.25	19.88	15.90
Pittsburgh, Pa.	54.71	82.07	19.88	15.90
Portland, Ore.	86.06	129.09	26.25	21.00
St. Louis, Mo.	33.32	49.98	10.88	8.70
San Francisco, Cal.	63.30	94.95	18.00	14.40
Seattle, Wash.	90.79	136.19	26.75	21.00
Washington, D. C.	59.29	88.94	18.00	14.40

Detailed notice of Post Convention Tours will appear later.

NOMINATIONS FOR OFFICERS AND DIRECTORS OF THE N.O.P.H.N. SECTIONS

Suggestions will be welcomed by the nominating committee of the School Nursing Section for names of officers and directors to be elected at the Biennial Convention. Suggestions should be sent to the National Organization for Public Health Nursing.

The present officers whose terms expire in 1932, are:

Chairman—Ann Dickie Boyd, Denver, Colo.
Vice-Chairman—Mary E. Chayer, New York, N. Y.
Lay Director—Dr. Edna Bailey, Berkeley, Cal.
Nurse Member—B. B. Randle, Grand Rapids, Mich.
Non-Nurse Member—Elma Rood, Detroit, Mich.

Nominations for the Board Members Section should be sent to the chairman of the Nominating Committee, Miss Anna M. L. Huber, 333 East Market Street, York, Penn.

Present officers, all of whose terms expire in 1932, are:

Chairman—Mrs. Whitman Cross, Chevy Chase, Md.
Vice-Chairman—Mrs. C.-E. A. Winslow, New Haven, Conn.
Directors—Mrs. A. R. Flickwir, Houston, Texas.
Alice Griffith, San Francisco, Cal.
Mrs. Richard Noye, Buffalo, N. Y.
Anna M. L. Huber, York, Pa.
Nurse Directors—Ruth Houlton, Minneapolis, Minn.
Juanita Woods, Richmond, Va.
Mrs. Ivah Uffelman, Nashville, Tenn.

Nominations for the Industrial Nursing Section should be sent to the chairman of the nominating committee, Mrs. Elizabeth W. Emery, 1 Post Street, Yonkers, N. Y.

Present officers whose terms expire in 1932 are:

Chairman—Grace M. Heidel, Albany, N. Y.
Vice-Chairman–Secretary—A. M. Lundine, South Manchester, Conn.
Nurse Members—Ruth C. Waterbury, New York, N. Y.
Mrs. Kathryn Page, San Francisco, Cal.
Nettie Amundsen, Milwaukee, Wis.
Lay Members—Mrs. Austin Levy, Harrisville, R. I.
Dr. William A. Sawyer, Rochester, N. Y.
Vacancy caused by the death of G. A. Orth.
James W. Towson, New York, N. Y.

SERVICE GIVEN BY JOINT VOCATIONAL SERVICE TO TAX-SUPPORTED ORGANIZATIONS

At least one of every four positions closed out during the first ten months of 1931 by Joint Vocational Service, according to a study made in November, was in public health nursing or public welfare work distinctly maintained through taxation. In 1928, about 18 per cent of the positions closed out by the Service were in such agencies, as compared with 23 per cent in 1930, and 25 per cent in 1931.

In addition to suggesting the names of candidates and sending their professional records and references to the persons reporting positions, Joint Vocational Service also keeps as closely in touch as possible with civil service openings and notifies those registered at the Service who would be interested in applying. In keeping with the trend so apparent now, namely, rapid expansion in programs receiving public appropriations, the Service constantly urges workers to make themselves eligible for opportunities in public health or public welfare departments as well as for positions in voluntarily supported organizations.

As Joint Vocational Service is not self-supporting, this natural development of service to tax-supported agencies brings with it a financial problem that must be solved in the near future. About one-third of the support has been coming from fees paid by persons placed in positions, one-third from organizations voluntarily subscribing to the service, and one-third from foundations and other sources. For the most part legal restrictions prevent public agencies from making a subscription to any other association. And when a worker secures a position after competitive civil service examination, Joint Vocational Service cannot claim a placement and charge a fee.

The public positions, as well as those in private agencies, have been reported to Joint Vocational Service from all over the United States and beyond the borders. Nearly every phase of public health nursing and social work has been touched upon in these positions. A number of the public health nursing positions have been for school nurses and nurses in other kinds of child health work, but a still larger number have been for nurses in generalized community programs.

Perhaps one of the greatest obstacles that Joint Vocational Service is meeting, aside from the effect of economic conditions, is that of residence requirements, and varying regulations for State registration of nurses, but the fact that Joint Vocational Service fills positions in every State shows that such obstacles are overcome by a national vocational agency—one that is "more than an employment agency."

STUDENTS REGISTERED IN ACCREDITED COURSES

This year information as to the number of students registered in courses of public health nursing has been received from all of the 13 institutions giving courses accredited by the N.O.P.H.N.

NUMBER OF STUDENTS REGISTERED IN ACCREDITED COURSES OF PUBLIC HEALTH NURSING AND NUMBER OF CERTIFICATES AND DEGREES GIVEN ACADEMIC YEAR 1930-1931 AND SUMMER SESSION 1931

State	Institution	Year	Total registration	Graduate nurses registered	Undergraduate nurses registered	On full-time schedule	On part-time schedule	Cert. and Degrees given		
								Cert.	B.Sc. B.A.	M.S. or M.A.
		Aggregate registration	1564	1489	75	648*	483*	172	88	18
Calif.	Univ. of California Dept. of Hygiene Berkeley	Year 1930–1931	45	45	..	38	7	45	12	..
Mass.	Simmons College School of P. H. Nursing Boston	Year 1930–1931	117	70	47	117	..	15	9	..
Mich.	Univ. of Michigan Dept. of P. H. Nursing Ann Arbor	Year 1930–1931	21	21	..	17	4	8	4	1
		Summer Session	43	43	..	43	..	..	..	..
	College of the City of Detroit Dept. of Nursing Educ'n Detroit	Year 1930–1931	367	364	3	4	363	1	..	..
		Summer Session	3	3	..	..	3	..	..	..
Minn.	Univ. of Minnesota Dept. of P. H. Nursing Minneapolis	Year 1930–1931	76	76	..	66	10	35	12	..
		Summer Session	88	86	2	86	2	..	..	..
Mo.	Washington University School of Nursing St. Louis	Year 1930–1931	8	8	..	8	..	4	..	..
		Summer Session	33	33	..	17	16	..	..	..
N. Y.	Columbia University Teachers College Dept. of Nursing Educ'n New York City	Year 1930–1931	261	261	..	*	*	..	30	11
		Summer Session	139	139	..	*	*	..	..	..
Ohio	Western Reserve Univ. Sch. of Applied Soc. Sc. Cleveland	Year 1930–1931	27	22	5	26	1	14	5	1
		Summer Session	51	51	..	38	13	..	..	..
Ore.	University of Oregon Sch. of Social Work Portland	Year 1930–1931	8	7	1	8	..	8	2	..
		Summer Session	14	14	..	14	..	..	..	..
Penn.	School of Social and Health Work Dept. of P. H. Nursing Philadelphia	Year 1930–1931	17	17	..	16	1	7	..	..
		Summer Session	80	80	..	33	47	..	..	..
Tenn.	George Peabody College Dept. of Nursing Educ'n Nashville	Year 1930–1931	27	27	..	22	5	8	6	2
		Summer Session	58	58	..	55	3	..	..	..
Va	Richmond School of Social Work Richmond	Year 1930–1931	18	12	6	18	..	4	..	..
		Summer Session	8	3	5	..	8	..	..	..
Wash.	Univ. of Washington Dept. of Nursing Seattle	Year 1930–1931	33	27	6	*	*	23	8	3
		Summer Session	22	22	..	22	..	..	..	..

* Information incomplete.

Other information relating to public health nursing courses was gathered and is briefly summarized as follows:

A total of 808 nurses, including 756 graduate nurses and 52 undergraduate nurses, are registered this fall in the 13 accredited courses of public health nursing.

A total of 191 nurses graduated, or completed all courses required for a certificate in public health nursing, during the academic year 1930–1931; 157 of these students are known to have been placed in positions, and 57 of the positions are in rural communities. No figures for Teachers College, New York City, are included, as Teachers College does not give a certificate in public health nursing.

Changes noted by some of the course directors:

In the type of public health nursing training wanted by students:
More preparation for rural services
More preparation for work with official agencies
More preparation for teaching, supervisory, and administrative positions
More preparation in mental hygiene
More preparation in public speaking

In the requirements for positions:
Higher academic training; degrees demanded
More knowledge of public health science
Better training for county and rural positions.

N.O.P.H.N. STATISTICAL SERVICE

MINIMUM REQUIREMENTS FOR APPROVED POST-GRADUATE COURSES IN PUBLIC HEALTH NURSING

As Established by the Education Committee of the National Organization for Public Health Nursing

1. An approved post-graduate course in public health nursing should be established in a college, university, or other school of collegiate grade, which allows academic credit for matriculated students.
2. The course should be under the direction of a nurse who is competent to teach and supervise public health nursing. She is responsible for the standard of work both theoretical and practical. It is highly desirable that she should be a college graduate.
3. The minimum time required for a course leading to a certificate is one academic year of approximately nine months, of which not less than four months, or its equivalent, should be given to supervised field work.
4. The course should include instruction in the following:

   a. Theoretical work
      (1) Principles and practices of public health nursing in its several branches
      (2) Educational psychology and mental hygiene
      (3) Public health administration including the prevention and control of communicable disease and sanitation
      (4) Social sciences including sociology and principles of family case work
      (5) Nutrition

   b. Field work
      This should be given only in established community organizations which provide adequate personnel and supervision, and a sufficient volume and variety of services.
      (1) Public health nursing—It is desirable that the experience in public health nursing include promotion of health, prevention of illness, and care of the sick.
      (2) Social case work—This should be practiced under the supervision of a trained social worker, preferably in connection with a well organized social agency.

Note: Consideration for a limited period of time is always given by the Education Committee for special adaptations or variations from these requirements due to local circumstances.

PUT A STAR BESIDE YOUR STATE

State	Total Number of Members December 1, 1931	Number of Nurses (Estimated from 1931 Census)	State	Total Number of Members December 1, 1931	Number of Nurses (Estimated from 1931 Census)
*Alabama	19	120	Nebraska	17	140
Arizona	18	45	Nevada	1	10
*Arkansas	32	40	New Hampshire	17	160
*California	191	640	*New Jersey	243	820
*Colorado	43	125	New Mexico	19	25
*Connecticut	211	500	*New York	858	2520
Delaware	16	65	*North Carolina	44	165
District of Columbia	48	75	*North Dakota	15	35
*Florida	32	60	*Ohio	212	1000
*Georgia	54	135	*Oklahoma	39	75
Idaho	5	15	*Oregon	38	65
*Illinois	258	1050	*Pennsylvania	375	1300
*Indiana	105	325	*Rhode Island	152	180
*Iowa	66	242	South Carolina	19	65
*Kansas	64	160	South Dakota	10	50
*Kentucky	98	150	*Tennessee	75	185
Louisiana	16	110	*Texas	95	185
*Maine	52	120	Utah	11	55
*Maryland	39	300	Vermont	21	55
*Massachusetts	365	1130	*Virginia	77	250
*Michigan	271	700	*Washington	43	150
*Minnesota	133	425	*West Virginia	48	90
Mississippi	10	50	*Wisconsin	92	340
*Missouri	196	325	Wyoming	4	25
Montana	18	35			

*** States which showed an advance in membership during November.**

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR JANUARY, 1932

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by KATHARINE BIGGS MCKINNEY

MONTHLY REPORTS—DEAD OR ALIVE?

We have asked two presidents of public health nursing agencies to tell us what kind of material they like to have the executive director report to the board each month. Both presidents write that they have "live" meetings. We hope other good ideas will be sent in for publication and mutual benefit.

From Grace S. Frost, President, Toledo (Ohio) District Nurse Association:

I am glad to give the point of view of the trustees of the Toledo District Nurse Association as to what we like to hear from the nurse director at our monthly meetings.

We believe that the superintendent should give a full account of the staff activities and should make it her duty to inform the board members of any new developments in public health nursing. We realize that the material contained in the superintendent's report must necessarily be influenced in different organizations by the information brought to the board through the various committees. In the Toledo Association, for instance, the superintendent has previously discussed perplexing problems and changes of policy with the nursing committee, which makes recommendations on these matters to the board, while important current events in public health are reported by the trustees' educational committee. But vary as the contents may, it is from the superintendent's report that the trustees gain a knowledge of the work as a whole, and her presentation should stimulate their interest and aid them in conducting the affairs of the Association with the utmost wisdom.

The following outline of the material given by the Toledo superintendent at the board meetings indicates the manner in which she endeavors to accomplish these ends. She does not present a written report but speaks from notes, the trustees gladly granting her from twenty minutes to half an hour.

She begins with the month's statistics, comparing the service rendered with that of the previous month and year, and calls attention to any striking features, such as a marked increase in the number of patients, the prevalence of certain diseases, an increase or decrease in fees from insurance companies and patients or an unusually high number of visits made by the staff in one day. To give variety to her reports, she avoids analyzing similar statistics at successive meetings.

Occasionally, the figures are presented in the form of graphs or on mimeographed sheets which are distributed to the members present and mailed to the absentees. In case a survey or study of any department has been made, this is explained by the superintendent. The trustees are informed each month of the number of days of sickness among the nurses, for the welfare of the staff is one of their chief concerns.

In order to present as vivid a picture of the work as possible, the superintendent makes brief mention of its various branches, giving illuminating facts in regard to the clinics, the maternity, infant welfare, tuberculosis and general nursing, and she also reads short excerpts from the reports of the orthopedic, nutrition, vocational and social service workers. She cites an interesting case or two, or may read one of the so-called "stories" of the work written twice a year by the nurses.

She tells who the speakers have been at the nurses' conferences, and where and when members of the staff have given talks. Through the reports she makes on various institutes or state and national meetings, she brings to the board the most recent trends in public health nursing and other social work.

In concluding, the superintendent reads a list of the donations for the month, as without this information the trustees might not be aware of the thoughtfulness and generosity shown by the many friends of the association.

From Lydia B. Stokes (Mrs. S. Emlen Stokes), President, Moorestown (N. J.) Visiting Nurse Association:

Our director's report varies monthly. There is only one routine that we follow—namely, to have a statistical report of the number and kinds of cases seen, along with the money collected from patients or from policyholders. Special phases of the work are always given, one phase at a time.

For example, we may be stressing child hygiene work, especially near the time of our large annual health day. Then again, a comparative study may be made among nearby communities. It is most encouraging to find how we stand in relation to larger communities. Thus we can tell whether we are giving an average service, or one a bit above the average, which we strive for.

Sometimes a detailed school nursing report is given, or a report on work among preschool children.

When any of our staff have been to meetings or conventions, a report is always given. Also, our director reports on her talks to parent-teacher associations, girl scouts, mothers' club, etc. Recently, she brought to the attention of the board, the board of health situation, and distributed among us "Your Friend the Health Officer."* Our publicity committee took the matter up in detail and constructive steps were taken and much study and thought put on our local situation.

Not only does our director report, but usually one of the staff nurses tells us of any special work she has on hand. Leading questions are asked.

Our meetings are really very alive, due in large part to our forward-looking staff members, who give the board ideas on which to work. These in turn are followed by the board in a most thorough way, and if they prove knotty problems they are referred for help to our big mother organization, the N.O.P.H.N.

*** Recent publication of the John Hancock Mutual Life Insurance Company, Boston, Mass. Free copies are available.** **See "Book Notes," page 56.**

REPORT OF STATE MEETINGS

On December 4, 1931, the Lay Section of the New Jersey State Organization for Public Health Nursing was definitely organized. Board members from many organizations met in the morning with the State Conference of Social Work and listened to a splendid discussion on Community Organization with Mrs. Lewis Thompson, Dr. Ellen Potter and Mr. Eduard C. Lindeman as speakers.

At a luncheon the Section was organized and Mrs. Howell Woolley, Long Branch, was elected President; Mrs. S. Emlen Stokes of Moorestown, Vice President; and Mrs. Roger Young, Jr., of Newark, Secretary. A simple Constitution and By-Laws were adopted and interest shown in holding regional conferences as well as the regular annual meeting.

In the afternoon Dr. Haven Emerson and Dr. Potter gave the group some very fine points on "The Indispensable Share of the Laity and the Lay-Worker in Modern Preventive Medicine" and the "Responsibilities of Board Members."

There was a registration representing 25 agencies at the meeting held in Pittsburgh in November at the time of the Pennsylvania State Nurses meeting. Mrs. Schiller, past President of the Pittsburgh Visiting Nurse Association, welcomed the delegates and Mrs. Ralph A. Amerman of Scranton presided.

Miss Huber, President of the York Visiting Nurse Association, presented reasons for having an organized Lay Section of the S.O.P.H.N. Mrs. Amerman presented the By-Laws, which after discussion were adopted, with the motion that any necessary changes be made by the Executive Committee, and formally presented at the next meeting.

The group elected the following officers for the year 1932:

President—Mrs. Ralph A. Amerman, Scranton
Vice President—Mrs. Samuel Miller, Lancaster
Secretary—Mrs. Meade D. Detweiler, Jr.

Miss Tucker, General Director of the N.O.P.H.N., gave an inspiring and comprehensive presentation of the important rôle board members play in the local, State and National public health movement.

THE BOARD MEMBER AND N.O.P.H.N. MEMBERSHIP

A member of a board of a small mid-western public health nursing organization was approached by the nurse director on the subject of membership in the N.O.P.H.N. She listened politely while the director briefly outlined the purposes and accomplishments of the organization, but when she was asked to enroll, the board member looked somewhat surprised.

"But Miss Blank," she protested, "why should I join a nurses' organization?"

The board member's question was based on a widespread but mistaken belief that the N.O.P.H.N. is purely a "nurses' organization," which it emphatically is not. The purpose of the organization is to advance standards and to stimulate and broaden the nation-wide public health nursing movement. The N.O.P.H.N. activities directed to these ends are as important to board members as citizens, as they are to nurses, and to the progress of health education in the country today.

It is evident that a citizen-group should help form the policies and direct the activities of public health nursing associations. But unless this citizen-group keeps itself well informed, and is intelligently aware of the constant improvements in the administrative practices of local organizations for which it is responsible, there is an unfortunate possibility that out-moded administration will seriously retard the association's effectiveness.

How, for example, can the average board member determine what salaries should be paid to nurse executives and staff? As a trustee for funds which have been collected for a definite purpose the board member ought not to approve salaries that are disproportionately high; equally important, to secure competent and satisfied nurses, she ought not to sanction salaries that are too low. The N.O.P.H.N. makes an annual salary study to provide an up-to-date basis for determining equitable rates.

How, too, can the board member determine whether the organization of her association is sound; whether the finance committee is functioning properly; whether her organization is wastefully duplicating the work of other agencies; or what types of service her organization should be giving to meet her community needs most effectively?

These are but a few of the important questions which every board member must face, and into every one of them the activities of the N.O.P.H.N. project themselves. A wide-awake, active and well informed board member is in a position to render her community a valuable service. She is as much a part of the public health movement as the nurse who makes her daily visits. As a vital part of that movement she needs the services of the N.O.P.H.N., and the N.O.P.H.N. needs her.

PLEASE NOTE!

Will all those who have suggestions for officers and directors of the N.O.P.H.N. Board and Committee Members Section, please see page 47.

Reprints of the article "The Volunteer in Public Health Nursing" by Evelyn K. Davis, assistant director of the N.O.P.H.N., which appeared in the *Junior League Magazine* for December 1931, are now available upon request from the N.O.P.H.N. The article is one of a series on training courses for volunteers in various fields. Topics for study in preparation for volunteer work in a public health nursing agency are suggested.

It is of interest that as a result of the N.O.P.H.N. study program for boards and committees, the following significant comment has come to us in correspondence: "A discussion of the functions of a social service exchange led to an interest in planning for the establishment of an exchange locally."

REVIEWS AND BOOK NOTES

Edited by RUTH GILBERT

JURISPRUDENCE FOR NURSES

By Carl Scheffel. Lakeside Publishing Company, New York. Price $2.00.

The law, as an indispensable attribute of civilization and orderly government, hovers over all persons. It applies as impartially to the professional man and woman as to the layman, and it is axiomatic that ignorance of the law does not offer a valid excuse for its violation or neglect.

In the nursing curriculum, jurisprudence is seldom stressed. The practicing nurse is certain, however, to be confronted sooner or later with l gal problems of some significance and it behooves her, therefore, to be safeguarded with knowledge concerning her legal liabilities and responsibilities.

This practical book will prove of value in giving such necessary information to all members of the nursing profession, especially since it is the only text of its kind. As a physician and lawyer, the author is well qualified to present the subject and he has done so in an eminently practical, if not always brilliant, manner.

Among the topics discussed are the legal status of nurses, with comments on the differences between the practices of medicine and nursing; the legal obligations of nurses to physicians and patients; nurses and contracts; nurses and wills; nurses as witnesses; and the responsibility of nurses in criminal procedure. There is comparatively little material directly on the subject of public health, but the principles set forth apply in general to all nurses, public health as well as bedside or institutional.

The text is fortified with allusions to and citations of actual court cases in which the judicial branch of our government has decided causes of action involving statutes and the common law. There is also appended to each chapter a list of quiz questions which will be useful in reviewing the subjects presented.

Just as no medical book can take the place of a competent physician, this book should not be considered as a substitute for a reliable attorney. It should, however, prove indispensable to nurses who desire and need a working conception of those essential rules of civil and public conduct known as The Law. The book is well printed and has a good index. It is a notable contribution to nursing practice and is to be highly commended as such.

JAMES A. TOBEY.

HEALTH HORIZONS

By Jean Broadhurst and Marion O. Lerrigo. Silver, Burdett and Co., New York. Price $3.00.

To one who did not have the privilege of knowing Emma Dolfinger, this book recently published as a memorial to her, brings a profound sense of the influence, direct and indirect, that she exerted in the field to which she devoted the best years of her life—that of Health Education. Infinite care has been used in designing the appearance of the book—from the soft green binding to the quiet inspiration of the end-leaves on which is portrayed a facsimile of Miss Dolfinger's personal book plates.

Of even greater tribute than the brief Foreword and description of Miss Dolfinger's life which prefaces the book, is the content of the book itself, for "Health Horizons" is, as the title page suggests, a source book of health teaching painstakingly and imaginatively put together from over five hundred sources. Designed primarily for the use of teachers as an aid in working out their program of health teaching with children, it should prove of particular value to both teacher and

nurse who wish to have at hand a discriminating selection of authoritative material covering the fields of science, medicine and public health.

The book is divided into twenty-three sections dealing with the major topics that affect the health of the individual: Air and ventilation; food and nutrition; heredity and eugenics; personal hygiene,—to mention just a few. Each topic contains a brief description of its history throughout the ages, as well as present-day applications in the light of modern scientific research, giving at the end of each section the source from which the material was selected. Otherwise prosaic subjects such as a balanced diet, occupational health and personal cleanliness are enlivened by descriptions of "Admiral Byrd's New Year's Dinner in Little America"; "How the Circus Keeps Healthy"; and "The Cleanly Congo Natives."

The complete bibliography from which the material was taken is given at the end, together with a detailed index.

The class-room teacher will welcome the help that this book should give in planning her health education program for her children.

DOROTHY J. CARTER.

Richard Berkeley's play *The Lady with A Lamp*, presenting scenes from the life of Florence Nightingale, has come to New York City following a successful run in England. Miss Edith Evans taking the part of Miss Nightingale, gives the play such vigor as it has, but at best the action is slow, and the two main lines of interest—Miss Nightingale's struggle to win recognition for nurses, indeed, for women, in nineteenth century England, and her love affair with "Henry Tremayne" (a stage name—not the name of her real lover)—are barely dramatic enough to hold the attention of a lay audience, until the last scene, which luckily is worth waiting for. For nurses, however, there is a decided glamor in watching a professional rendering of the events in Miss Nightingale's life, in hearing her pointed comments on nursing,—familiar to us all through our "history of nursing,"—and in realizing afresh with what wisdom and tireless energy, she fought for her ideals which, in so many instances, are still our ideals sixty years later, although the psychology of our "attack" might differ.

Miss Evans's sympathetic interpretation of Miss Nightingale's last days deserves high praise, and the scene in which the delayed honors are bestowed on the weary, blind, senile invalid, will never be forgotten by those who saw it.

D. D.

Lengthening the Span of Life, the last paper presented by Dr. Lee K. Frankel, is now available in reprint form. This material originally given in an address to the American Philosophical Society at Philadelphia, summarizes some of the health accomplishments of the past and describes prospects for continued progress in this field.

A newcomer has joined the ranks of State journals. The Alabama State Medical Society and the State Board of Health are publishing as their official organ, The Journal of the Medical Association of the State of Alabama.

Your Friend, The Health Officer, a timely booklet just issued, is a contribution of the John Hancock Mutual Life Insurance Company, Boston. Feeling that few "lay people" have any real idea of the variety of services that go to make up the work of the public health department, the author, Dr. Wilson G. Smillie, has designed his material for the man-in-the-street. This booklet is good ammunition for the nurse or organization needing a piece of practical publicity material which will appeal to the masculine element of the community, to boards of supervisors and to organized groups. The pamphlet consists of fourteen pages, illustrated.

WHITE HOUSE CONFERENCE PUBLICATIONS

Because material resulting from the White House Conference on Child Health and Protection is appearing in print so rapidly, we are in danger of missing valuable aids to our work through sheer inability to "keep up" with the publisher. The following resumé of *White House Conference material now available* may be helpful in this respect. Reviews of a number of the books will appear in Book Notes as space permits. The volumes, attractive in printing and arrangement, are published by The Century Company, New York City.

THE CHILDREN'S CHARTER. Size 17 x 19. Price, single copies, 20c, gold, blue, black on white; 15c, red and black on ivory. Framed, $2.50 plus postage. Address the Conference at Central Administrative Office, Interior Building, Washington, D. C.

WHITE HOUSE CONFERENCE, 1930. Abstracts of the reports of the committees of the Conference, and addresses of the General Conference. Boards, 50c; cloth, $2.00.

HEALTH PROTECTION FOR THE PRESCHOOL CHILD. A National Survey of the use of Preventive Medical and Dental Service for preschool children by the Committee on Medical Care for Children. Cloth, $2.00.

THE HOME AND THE CHILD. Report of the Subcommittee on Housing and Home Management of the Committee on The Family and Parent Education (Section III—Education and Training). Cloth, illustrated, $2.00.

PEDIATRIC EDUCATION. Report of the Subcommittee on Medical Education of the Committee on Medical Care (Section I—Medical Service). Paper, 50 cents.

COMMUNICABLE DISEASE CONTROL. Report of the Committee on Communicable Disease Control (Section II—Public Health Service and Administration). Cloth, $2.25. (Reviewed in this issue.)

NURSERY EDUCATION. A survey of institutions for the education and training of the child under six by the Committee on the Infant and Preschool Child (Section III—Education and Training). Cloth, $2.00.

A series of pamphlets on *Growth, Personality,* and *Habits* is reviewed in this issue.

Suggestions for Three Community Studies. The studies as outlined in this pamphlet include "Public Health Service and Administration"; "Education and Training"; "The Handicapped Child." Study questions and work sheets are given space in the pamphlet. Available from the American Child Health Association, 450 Seventh Avenue, New York City. Single copies free; 100 copies $4.32; 100 copies plus addition of local organization's name in print as distributor, $6.57.

COMMUNICABLE DISEASE CONTROL

Report of the Committee on the Control of Communicable Diseases of the White House Conference on Child Health and Protection. The Century Company, New York. $2.25.

Have you ever been asked out of a clear sky, what the childhood diseases are? A quick reply usually states, "Measles, chickenpox, mumps, and ——." You must stop and think a bit to give a complete list. The Committee on the Control of Communicable Diseases of the White House Conference on Child Health and Protection answers this question definitely. This statement is based on a study of communicable disease incidence in three states—Massachusetts, New York, and Kansas—to discover percentages for each disease occurring in the age group under 20.

The following percentages were obtained: Whooping cough, 91.1; measles, 90; poliomyelitis, 90; scarlet fever, 85.2; German measles, 83; mumps, 81.7; diphtheria, 81.4; epidemic meningitis, 75.6; smallpox, 57.5.

Tuberculosis (all forms), on the

other hand, claimed only 21.4 per cent of its total cases in this age group; lobar pneumonia, 34.5; and typhoid fever, 43.4.

Studies made of morbidity and death rates over a period of years have revealed the following facts:

1. The so-called communicable diseases attacking children have little seasonal variation from year to year. The peak of the illness from diphtheria is reached in October and November; scarlet fever, meningococcus meningitis, whooping cough and smallpox, in January, February and March; measles in March, April and May; poliomyelitis in August and September. Variations exist in different sections of the country.

2. The greatest killer of the group under 20 years is broncho-pneumonia. Tuberculosis comes second, with lobar pneumonia, diphtheria, and whooping cough taking third, fourth, and fifth places.

3. If it is impossible to prevent them wholly, it is very desirable to postpone attacks of measles, scarlet fever, whooping cough, mumps, until after ten years of age. A study of the morbidity and mortality rates of these and of the more alarming diseases such as diphtheria, poliomyelitis, meningitis and broncho-pneumonia shows that although the age group under one year has the smallest percentage of the total number of cases, its fatality rate is the highest of all the groups under 20 years.

4. In a survey of absences from school in Cleveland among white children, communicable diseases represented almost 65 per cent of the total. Another study made by the United States Public Health Service showed colds as the chief cause of absence from school among 6,130 school children.

5. Where special preventive measures are in use, such as exist for diphtheria, typhoid and smallpox, and where reporting of communicable diseases to the board of health is fairly well established, there is a distinct reduction in the number of cases within the ten-year period, 1919–1928.

6. Death rates from communicable diseases among children have, in general, been dropping almost twice as fast in urban communities as in rural.

—Adapted from Red Cross Courier.

The increasingly large number of nurses who are using "Child Care and Training" by Marion L. Faegre and Dr. John E. Anderson (reviewed May, 1931), will welcome these new booklets by Mrs. Faegre entitled respectively, *Growth; Habits; Personality*. These three booklets embody the fifteen leaflets on these subjects prepared by Mrs. Faegre for the White House Conference on Child Health and Protection.

In order to place the material before as many women in rural areas as possible, The Farmer's Wife, St. Paul, Minnesota, has reprinted the leaflets in the three booklets described at the reduced combination price of $.45, a price which covers the cost of printing only.

The following attractive and helpful pamphlets, in revised form, are available from the Metropolitan Life Insurance Company, New York City: *Conquest of Typhoid Fever; First Aid; Good Teeth; Good Habits for Children* (prepared with the coöperation and advice of the National Committee for Mental Hygiene). For copies of these pamphlets, address Welfare Division.

Attention is called to our reference to "Finding Tuberculosis among School Children" (PUBLIC HEALTH NURSING, September, 1931, page 455). This article recommends *no* "suggestions for screening out of a large school population the comparatively small group with tuberculous infection." The author believes an uncritical acceptance of screening methods has in the past set up extensive administrative machinery in school health programs that have misdirected funds and effort from productive lines of service. It is therefore important that we should avoid such errors in the future. The article in question emphasizes the need for more knowledge rather than presuming to suggest methods.

NEWS NOTES

The Governor's Conference on Child Welfare, held November 9–11 in Lansing, Michigan, was attended by 194 public health nurses representing the various agencies functioning throughout the State.

The programs on medical service and public health administration were particularly interesting to the nurses. The luncheon speaker was Miss Elma Rood who described the progress in nutritional instruction in the rural schools of Michigan as developed under the direction of the Children's Fund.

The Eleventh Annual Health Conference followed the Child Welfare meeting. An outstanding feature of the program was a paper by Dr. Don W. Gudakunst on "The Physician, the Nurse, and the Teacher in the School Health Program."

✤

Two types of contests for senior students in schools of nursing and for members of district associations (in states not districted—for members of alumnae associations) have been arranged by the American Nurses' Association for 1932. This step was taken in accordance with the action of the Board of Directors of the American Nurses' Association in September 1931, at which time it was voted to continue the contests along the same lines as those held during the spring of 1931 in connection with the Membership Campaign.

For details of the awards and rules for the contests, readers are referred to the *American Journal of Nursing* for January.

✤

Lois Harris, Frances Fell and Margaret Oetjen have returned from Scotland to the Frontier Nursing Service, having completed their training as midwives with the Queen's Nurses in Edinburgh, and passed the examination of the Scottish Central Midwives Board. Miss Oetjen also took six months graduate work in public health nursing with the Detroit Visiting Nurse Association.

Rose McNaught has been lent by the Frontier Nursing Service to the Association for the Promotion and Standardization of Midwifery in New York for the coming year, as Midwifery Supervisor of student nurse-midwives.

✤

With the approval of the Board of Education of New York City, the Visiting Nurse Association of Brooklyn, N. Y., is conducting a series of "at home" afternoons for the benefit of the high school students of Brooklyn. Between one and two hundred students have been asked to attend each week. Brief talks are given, the organization's moving picture shown, and an essay contest announced.

Acquisition of Florence Nightingale's house, 10, South Street, London, has been voted down by the Board of Directors of The Florence Nightingale Memorial Committee on the grounds that the house is in bad condition, the space available is small and the cost prohibitive. That the memorial take the form of an endowed Foundation for post-graduate nursing education, located in London, was the alternative which most appealed to the Board assembled in Geneva.

✤

By January, 1934, all candidates for examination by the Central Midwives' Board (England) must be "general trained nurses." They must be over twenty-five years of age; have been enrolled as midwives for over three years, and must have been Sister on the staff of a recognized training school for over two years or have had experience in district midwifery in a practice of at least one hundred cases a year.

✤

Special flat rates for maternity cases have been adopted at the Benedictine Hospital, Kingston, Ulster County, N. Y., as a step toward better prenatal care. A fee of fifty dollars is charged for a ten days' stay at the hospital. This includes hospital service, delivery room charges, care of the baby, dressings, and the services of the physician during clinic visits and confinement. Through this plan, it is hoped that patients who propose to go to the Benedictine Hospital for confinement will seek adequate prenatal care and thus eliminate many of the preventable risks of pregnancy. This system which has been adopted in a number of the larger institutions is apparently gaining well-deserved popularity.

✤

Arkansas sanitary inspectors in meeting with major health authorities and farmers for the purpose of discussing existing sanitary conditions in the cornfields, have decided to emphasize rural work in their program for the immediate future, and have adopted the slogan "Leaving Town for the Corn Fields."

✤

That mental disease is less prevalent among Jews than among non-Jews, and that the prevailing belief concerning the peculiar tendency of the Jew to mental disease is in the nature of a superstition, is the conclusion of Benjamin Malzberg, Assistant Director of the Statistical Bureau of the New York State Department of Mental Hygiene, in a study, reported to the National Committee for Mental Hygiene, of admissions to mental hospitals in New York, Massachusetts and Illinois.

"America's first day nursery fathers' club" has been organized at the Heckscher Foundation Nursery in Brooklyn, N. Y. Some members are young; some older; a grandfather, tacitly accepted by the rest as leader. The fathers are finding ways to help as well as to learn—applying their skills as carpenters, tailors, bricklayers. Joint meetings for fathers and mothers will be addressed by experts in various fields of child welfare.

✚

The 1930 death rate from whooping cough was the lowest ever recorded among insured children, according to a report of the Metropolitan Life Insurance Company. For children from 1 to 4 years of age, the death rate for this disease was 50 per cent less from 1926 to 1930, than from 1911 to 1915.

✚

The Statistical Bulletin of the Metropolitan Life Insurance Company stated recently that among nearly 20,000 employees of that company who received dental examinations in the last 12 years, only two sets of perfect teeth were found.

Will secretaries and publicity chairmen of all groups please read this request?

Our magazine is eager to be of more service in 1932 in listing dates of state meetings—indeed all meetings relating to public health nurses as well as public health nursing sections and S.O.P.H.Ns. However, it is necessary to have news announcements in the editorial office by the sixth of the month preceding the month of the meeting. We are always glad to report unusually successful meetings, also, particularly those that give program pointers. If sufficient state news is received, we will set aside a column of *News Notes* for State items. Unfortunately, lack of space prevents our publishing many personal notes.

APPOINTMENTS

Helen Bean, former nursing field representative of the Red Cross for Indiana, is succeeding Mildred Whiting as nursing field representative for Massachusetts. Miss Whiting recently married Howard Preston and is residing in Newark, Del., where Mr. Preston is connected with the University of Delaware.

Florence Spaulding as nursing field representative for Indiana, succeeding Helen Bean.

Rebecca M. Pond as nursing field representative in Minnesota and Wisconsin. For two years Miss Pond has been serving as an itinerant Red Cross nurse.

Thelma Jopling as staff nurse, Red Cross Chapter, Houston, Texas.

Florence E. Baker as Red Cross nurse in Carrollton, Ill.

Beatrice Kinney as Red Cross and county tuberculosis nurse at Moberly, Mo.

Lydia Mast as public health nurse, Elkader, Iowa. This service is under the direction of the Red Cross Chapter and the Tuberculosis Society of Clayton County.

Margaret H. Johnson as public health nurse, Polk County Red Cross Chapter, Crookstown, Minn.

Helen Myers, as public health nurse, Johnson County Red Cross Chapter, Olathe, Kansas. This service is in coöperation with the county commissioners.

Lucy Perry as public health nurse, Holt County Red Cross Chapter, Nebraska.

Irene Mildren Penn as public health nurse, Leavenworth County Red Cross Chapter, Kansas.

Florence Ferguson as county and Red Cross nurse, Finley, N. D.

Mrs. Bertha Chase Pederson as state field worker, Utah Tuberculosis Association, Salt Lake City, Utah.

Katherine Cameron as assistant director, American Red Cross Chapter, Hazleton, Pa.

Mrs. Alice B. Clarke as teacher nurse, High School, Fairfield, Conn.

Mrs. Cora G. Yaggy as school nurse, Public Schools, Hays, Kansas.

Rocia Dority, Thelma Munn, Susan Gale, F. Miriam Bailey, Urania Ostberg, as school nurses, Public Schools, Tulsa, Okla.

Charlotte Cowles has been appointed as psychiatric social worker in Dutchess County, N. Y. A mental hygiene program designed to help with the problems arising constantly in the work of the nurses in the county gradually will be developed. This is a pioneer attempt to develop mental hygiene activities in connection with a rural public health nursing program.

OFFICIAL DIRECTORY

This directory lists nurses holding executive State positions. The information supplied from the various agencies listed was correct on December 1, 1931. However, as changes in personnel occur constantly, we advise our readers who wish to use this list for any general purpose after March 1st to secure corrections from the National Organization for Public Health Nursing, 450 Seventh Avenue, New York City.

Official Directory

Listing nurses holding executive positions in states and officers of State Organizations for Public Health Nursing and Public Health Nursing Sections of State Nurses' Associations.

Information as of December 1, 1931.

The National Organization for Public Health Nursing, Inc. — President, Sophie C. Nelson, 197 Clarendon St., Boston, Mass. Director, Katharine Tucker, 450 Seventh Ave., New York, N. Y.

Nursing Service, American Red Cross—National Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Public Health Nursing Service, American Red Cross — National Director, I. Malinde Havey, American Red Cross, Washington, D. C.

Midwestern Area: Assistant Director, Mrs. Elsbeth Vaughan; Assistant Directors, Louise Kinney, Lona Trott, 1709 Washington Ave., St. Louis, Mo.

Pacific Area: Assistant Director, Rena Haig; Assistant Director, Eugenia Klinefelter, Larkin and Grove Sts., San Francisco, Cal.

Eastern Area: Assistant Directors, Margaret Reid, Annabelle Petersen, Myrtie E. Taylor, and Mrs. Charlotte Heilman, American Red Cross, Washington, D. C.

U. S. Army Nurse Corps—Superintendent, Major Julia C. Stimson, Dean, Army School of Nursing, Washington, D. C.

U. S. Navy Nurse Corps—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

U. S. Public Health Service, Nurse Corps—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

U. S. Veterans' Bureau Nursing Service—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau — Supervisor of Field Nurses and Field Matrons, Elinor D. Gregg, U. S. Department of the Interior, Office of Indian Affairs, Washington, D. C.

Alabama

State Board of Health—Bureau of Child Hygiene and Public Health Nursing, Director, Jessie L. Marriner, 519 Dexter Ave., Montgomery.

State Nurses' Association Paid Executive—Linna H. Denny, 1320 N. 25th St., Birmingham.

State Tuberculosis Association Field Nurse—Ellen B. Brown, 1001 Protective Life Bldg., Birmingham.

American Red Cross Nursing Field Representative—Margaret Dizney, American Red Cross, Washington, D. C.

Arizona

American Red Cross Nursing Field Representative—Calista Crown, Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.

Arkansas

State Organization for Public Health Nursing—Pres., Agnes McCall, Warren. Sec., Mary Sullivan, Health Nurse, Mt. Ida. Treas., Matie Neely, County Health Unit, El Dorado.

State Board of Health—Supervisor Public Health Nursing, Elizabeth Hoeltzel, Little Rock.

American Red Cross Nursing Field Representative — Ella Gimmestad, 1709 Washington Ave., St. Louis, Mo.

California

State Organization for Public Health Nursing—Pres., Mrs. Helen Halvorsen, 1926 Leighton Ave., Los Angeles. Sec., Mrs. Kathryn H. Saunders, 1521 Maple Ave., Los Angeles. Treas., Harriet Baird, 6610 Malabar St., Huntington Park. Chairman Membership Committee, Lona C. Dunham, 314 E. Union St., Pasadena.

State Department of Public Health—Ethel A. Fisher, Advisory Public Health Nurse, State Building, Los Angeles.

State Tuberculosis Association, Field Nurse—Beatrice Woodward, 582 Market St., San Francisco.

State Nurses' Association Paid Executive—Anna C. Jammé, Director at Headquarters, Room 502, 609 Sutter St., San Francisco.

American Red Cross Nursing Field Representative—Calista Crown, Civic Auditorium, Larkin and Grove Sts., San Francisco.

Colorado

Section on Public Health Nursing of State Nurses' Association—Chairman, Ruth Phillips, 305 Barth Block, Denver. Vice-Chairman, Mrs. Edith Embury Crane, Denver. Sec.-Treas., Madeline F. Buck, 414 14th St., Denver.

State Tuberculosis Association Field Nurse—Ruth E. Phillips, 305 Barth Bldg., Denver.
State Nurses' Association Paid Executive—Irene Murchison, 302 Capitol Bldg., Denver.
American Red Cross Nursing Field Representative—Elizabeth Reynolds, 1709 Washington Ave., St. Louis, Mo.

Connecticut

Section on Public Health Nursing of State Nurses' Association—Chairman, Florence Whipple, 35 Field St., Waterbury. Sec., Irma Reeve, 35 Elm St., New Haven. Chairman, Membership Committee, Rachel Colby, 205 W. Main St., New Britain.
State Department of Health—Bureau of Public Health Nursing, Director, Sarah R. Addison, Hartford.
State Nurses' Association Paid Executive—Margaret K. Stack, Executive Secretary, 175 Broad St., Hartford.
American Red Cross Nursing Field Representative—Sarah R. Addison, American Red Cross, Hartford.

Delaware

Section on Public Health Nursing of State Nurses' Association—Chairman, Mary Miller, Claymont. Vice-Chairman, Mrs. Anna Van W. Castle, 911 Delaware Ave., Wilmington. Sec., Elizabeth Ryan, Brandywine Sanatorium, Marshallton. Treas., Mrs. Marjorie McKay, 3216 Monroe St., Wilmington.
American Red Cross Nursing Field Representative—Cecilia P. Houston, American Red Cross, Washington, D. C.

District of Columbia

Section on Public Health Nursing of District Nurses' Association—Chairman, Mary C. Connor, 2308 Ashmead Place, N. W. Vice-Chairman, Edith B. Aldridge, 819 Allison St., N. W. Sec., Charlotte Hasselbusch, 637 Ingraham St., N. W.
District Department of Health — Child Welfare and Hygiene Service, Chief Nurse, Edith B. Aldridge, Washington.
District Tuberculosis Association Field Nurse—Grace V. Perry, 1022 Eleventh N. W., Washington, D. C.
District Nurses' Association Paid Executive—Bertha E. McAfee, 60–1746 K St., N. W.

Florida

Section on Public Health Nursing of State Nurses' Association — Chairman, Julia Graves, State Board of Health, Jacksonville. Vice-Chairman, Betty Henhegy, 316 Ridgewood Ave., Orlando. Sec., Cecilia O'Berry, Plant City.
State Board of Health—Chief of Nursing Division, Clio McLaughlin, Jacksonville.
American Red Cross Nursing Field Representative—Ruth Mettinger, American Red Cross, Washington, D. C.

Georgia

State Organization for Public Health Nursing—Pres., Anne Rivers, Health Dept., City Hall, Savannah. Sec., Mariana Ward, 23 Charlton St., Savannah. Treas., Vera Mingledorf, 23 Charlton St., Savannah. Chairman of Membership Committee, Lillian Alexander, Health Department, City Hall, Atlanta.
State Tuberculosis Association Field Nurse—Ada M. Whyte, 282 Forrest Ave., N. E., Atlanta.
State Nurses' Association Paid Executive—Jane Van de Vrede, Executive Secretary, 131 Forrest Ave., N. E., Atlanta.
American Red Cross Nursing Field Representative—Ruth Mettinger, American Red Cross, Washington, D. C.

Idaho

State Tuberculosis Association Field Nurse—Margaret Thomas, Idaho Anti-Tuberculosis Association, 320 Boise City National Bank Bldg., Boise.
American Red Cross Nursing Field Representative — Gladyce Badger, Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.

Illinois

Section on Public Health Nursing of State Nurses' Association—Chairman, Harriet Fulmer, Cook County Bureau of Public Welfare, 737 S. Lincoln St., Chicago. Sec., Mary Jane Fee, Champaign.
State Department of Public Health—Division of Child Hygiene and Public Health Nursing, Leone W. Ware, Chief Supervising Nurse, Springfield.
State Tuberculosis Association—Alpha Rosenberger, Security Bldg., Springfield.
American Red Cross Nursing Field Representative — Mrs. Barbara Fletcher, 1709 Washington Ave., St. Louis, Mo.

Indiana

Section on Public Health Nursing of State Nurses' Association — Chairman, Eva MacDougall, State Department of Health, Indianapolis. Sec., Alma Ohlstrum, Whiting.
State Board of Health—Division of Public Health Nursing, Director, Eva F. MacDougall, 6 State House Annex, Indianapolis.
State Tuberculosis Association Field Nurse — Mrs. Anna E. Sims, 1219 Meyer-Kiser Bank Bldg., Indianapolis.
State Nurses' Association Paid Executive—Helen Teal, 1211 Circle Tower, Indianapolis.
American Red Cross Nursing Field Representative—Florence Spaulding, American Red Cross, Washington, D. C.

Iowa

Section on Public Health Nursing of State Nurses' Association—Chairman, Esta Will, Rock Rapids. Sec., Alma Hartz, Bureau of Maternity and Infant Hygiene, State Department of Health, Des Moines.

State Department of Health—Edith S. Countryman, Director Public Health Nursing, State House, Des Moines.

State Tuberculosis Association Field Nurse—Ruth Walker, In Charge of Clinics, 518 Frankel Bldg., Des Moines.

American Red Cross Nursing Field Representative — Thora Ingbritson, 1709 Washington Ave., St. Louis, Mo.

Kansas

State Organization for Public Health Nursing (Not a branch of N.O.P.H.N.) —Pres., E. Fredericka Beal, High School, Topeka. Sec. and Treas., Lucille Thomas, Newton Public Health Nursing Association, Newton.

State Board of Health—Mary McAuliffe, State Public Health Nurse, Topeka.

State Tuberculosis Association Field Nurses—Mabel R. Marvin, 824 Kansas Ave., Topeka; Velma G. Long, Court House, Newton.

American Red Cross Nursing Field Representative — Linnie Beauchamp, 1709 Washington Ave., St. Louis, Mo.

Kentucky

State Organization for Public Health Nursing—Pres., Mrs. Myrtle C. Applegate, 2051 Sherwood Ave., Louisville. Sec., Anna B. Quinn, Heyburn Bldg., Louisville. Treas., Mrs. Claudine Barmore, 2103 Greenwood Ave., Louisville. Chairman Membership Committee, Margaret East, State Board of Health, Louisville.

State Board of Health—Margaret L. East, Director Bureau of Public Health Nursing, 532 W. Main St., Louisville.

State Tuberculosis Association Supervising Nurse—Margaret L. East, 532 West Main St., Louisville.

American Red Cross Nursing Field Representative—Margaret Dizney, American Red Cross, Washington, D. C.

Louisiana

Section on Public Health Nursing of State Nurses' Association—Chairman, Emma Maurin, 223 New Court Bldg., New Orleans. Vice-Chairman, Mrs. Amelia Dilts, Child Welfare, Audubon Bldg., New Orleans. Sec., Anna Barr, Metropolitan Life Insurance Co., New Orleans.

State Board of Health—Emma Maurin, Field Supervisor of Nurses, Bureau of Parish Health Administration, New Court House, New Orleans.

American Red Cross Nursing Field Representative—Margaret Dizney, American Red Cross, Washington, D. C.

Maine

Section on Public Health Nursing of State Nurses' Association—Chairman, Laura Knowlton, Box 75, Vassalboro. Sec.-Treas., Mrs. Katharine Dougherty, Room 47, City Hall, Portland.

State Department of Health—Edith L. Soule, Director of Public Health Nursing and Child Hygiene, Augusta.

State Tuberculosis Association Field Nurse—Mrs. Theresa R. Anderson, Maine Public Health Association, 256 Water St., Augusta.

American Red Cross Nursing Field Representative—Laura Knowlton, American Red Cross, Washington, D. C.

Maryland

State Organization for Public Health Nursing—Pres., M. G. Wesley, 4638 Keswick Rd., Baltimore. Sec., Grace B. Ridgaway, 4329 Park Heights Ave., Baltimore. Treas., Dorothea Tag, 611 Tunbridge Road, Baltimore. Chairman Membership Committee, Mrs. Jane B. Laib, City Health Department, Baltimore.

State Tuberculosis Association Field Nurse—Mattie M. Smith, 900 St. Paul St., Baltimore.

State Association Paid Executive—Sarah F. Martin, Executive Secretary, 1211 Cathedral St., Baltimore.

American Red Cross Nursing Field Representatives — Cecilia Houston (east) and Marie Peterson (west), American Red Cross, Washington, D. C.

Massachusetts

State Organization for Public Health Nursing (Not a branch of N.O.P.H.N.) —Pres., Gertrude Peabody, 13 Kirkland St., Cambridge. Sec., Mrs. Harold A. Marvin, Chestnut Hill. Treas., Marie Knowles, Boston.

State Department of Public Health—Division of Child Hygiene, Mary P. Billmeyer, Dept. Consultant in Public Health Nursing, 546 State House, Boston.

State Nurses' Association Paid Executive—Helene G. Lee, 420 Boylston St., Boston.

American Red Cross Nursing Field Representative—Helen Bean, American Red Cross, Washington, D. C.

Michigan

State Department of Health—Bureau of Child Hygiene and Public Health Nursing, Assistant Director, Mrs. Helen deSpelder Moore, Lansing.

State Tuberculosis Association Field Nurse—Ethel W. Langenberg, 535 So. Capitol Ave., Lansing.

State Nurses' Association Paid Executive —Olive Sewell, Capitol Loan and Savings Bank Bldg., 118 E. Allegan St., Lansing.

American Red Cross Nursing Field Representative — Mrs. Barbara Fletcher, 1709 Washington Ave., St. Louis, Mo.

Minnesota

State Organization for Public Health Nursing—Pres., Eula Butzerin, Student Health Service, University of Minnesota, Minneapolis. Sec., Margaret McGregor, 1003 Ivy St., St. Paul. Treas., Ann Nyquist, Div. of Child Hygiene, Mallard Hall, University of Minnesota. Chairman Membership Committee, Olivia Peterson, Mallard Hall, University of Minnesota.

State Department of Health—Bureau of Child Hygiene, Superintendent of Public Health Nursing, Olivia T. Peterson, University Campus, Minneapolis.

State Tuberculosis Association Field Nurses—Mrs. Alma Harvey and Mabel Johnson, Minnesota Public Health Association, 11 West Summit Ave., St. Paul.

State Nurses' Association Paid Executive —Caroline M. Rankiellour, 2642 University Ave., St. Paul.

American Red Cross Nursing Field Representative—Rebecca Pond, 1709 Washington Ave., St. Louis, Mo.

Mississippi

Section on Public Health Nursing of State Nurses' Association—Chairman, Ethel B. Marsh, care of Lee Parker, Natchez.

State Board of Health—Mary D. Osborne, Supervisor Public Health Nursing, and Maternal and Infant Hygiene, Jackson.

American Red Cross Nursing Field Representative — Margaret Dizney, American Red Cross, Washington, D. C.

Missouri

Section on Public Health Nursing of State Nurses' Association—Chairman, Phyllis M. Dacey, 1325 Rialto Bldg., Kansas City. Vice-Chairman, Mildred Sanderson, 35 Municipal Courts Bldg., St. Louis. Sec., Ella Reynolds, Court House, St. Joseph.

State Board of Health—Pearl McIver, Supervisor of Public Health Nursing, Jefferson City.

State Tuberculosis Association Field Nurse—Martha A. Sander, Missouri Tuberculosis Association, 2221 Locust St., St. Louis.

State Nurses' Association Paid Executive —Elizabeth Martin, 425 East 62d St., Kansas City.

American Red Cross Nursing Field Representative — Ella Gimmestad, 1709 Washington Ave., St. Louis.

Montana

State Department of Health—Supervisor Public Health Nurses, *Temporary vacancy.*

State Tuberculosis Association Field Nurse—Alta Walls, State House, Helena.

State Nurses' Association Paid Executive —Edith L. Brown, Box 928, Helena.

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

Nebraska

Section on Public Health Nursing of State Nurses' Association — Chairman, Mrs. Ethel Powers, City Hall, Omaha.

American Red Cross Nursing Field Representative — Elizabeth Reynolds, 1709 Washington Ave., St. Louis, Mo.

Nevada

State Tuberculosis Association Field Nurse—Mrs. Ebba Bishop, 419 Granite St., Reno.

New Hampshire

State Department of Health—Division of Maternity, Infancy and Child Hygiene, Mrs. Mary D. Davis, Supervising Nurse, State House, Concord.

State Board of Education—School Supervisor of Health, Elizabeth M. Murphy, Patriot Bldg., Concord.

American Red Cross Nursing Field Representative—Helen W. Gould, American Red Cross, Washington, D. C.

New Jersey

State Organization for Public Health Nursing—Pres., Mary E. Edgecomb, Englewood Hospital, Englewood. Sec., Edith Granger, 439 Main St., Orange. Treas., Ruth Fisher, Visiting Nurse Association, Plainfield. Chairman Membership Committee, Anne Ewing, 292 Broad St., Newark.

State Department of Health—Bureau of Child Hygiene, Alice F. Boyer, Supervisor of Child Hygiene Nurses and Administration, Trenton.

State Department of Public Instruction, Assistant in Health Education—Lula P. Dilworth, 1208 Trenton Trust Company Bldg., Trenton.

State Nurses' Association Paid Executive—Arabelle Creech, 42 Bleecker St., Newark.

American Red Cross Nursing Field Representative—Mrs. Belle Wagner, American Red Cross, Washington, D. C.

New Mexico

State Organization for Public Health Nursing — Pres., Mrs. Edith Hardy, Carlsbad. Sec. and Treas., Eleanor L. Kennedy, State Bureau of Health, Santa Fe. Vice-Pres., Mrs. Esther J. Schawbel, Roswell.

State Board of Health—Bureau of Public Health, State Supervisor of Public Health Nursing—Eleanor L. Kennedy, Santa Fe.

American Red Cross Nursing Field Representative — Ella Gimmestad, 1709 Washington Ave., St. Louis, Mo.

New York

State Organization for Public Health Nursing—Pres., Marie Swanson, State Department of Education, Albany. Sec., Margaret Westbrook, City Hall, Ogdensburg. Treas., Mrs. Tessa Klein, 181 Franklin St., Buffalo. Chairman Membership Committee, Mrs. Katherine Johnson, 10 Second Ave., Gloversville.

State Department of Health—Division of Public Health Nursing, Director, Mathilde S. Kuhlman, Albany.

State Department of Education—Supervisors of School Nurses, Anna M. Neukom and Marie E. Swanson, State Education Bldg., Albany.

State Tuberculosis Association Field Nurse—Mrs. Bessie P. Hanson, State Charities Aid Association, 105 East 22d St., New York.

State Nurses' Association Paid Executive —Emily J. Hicks, N. Y. State Nurses Association, 450 Seventh Ave., New York.

American Red Cross Nursing Field Representative — Mrs. Charlotte Heilman, American Red Cross, Washington, D. C.

North Carolina

Section on Public Health Nursing of State Nurses' Association—Chairman, Willie Burt Fuller, City Hall, Greensboro. Vice-Chairman, Mrs. Grady Morgan, Asheville. Sec., Edna McKee, Greenville.

American Red Cross Nursing Field Representative—Mary DeLaskey, American Red Cross, Washington, D. C.

North Dakota

Section on Public Health Nursing of State Nurses' Association — Chairman, Josephine Osland, Cavalier. Vice-Chairman, Nancy Lee Masters, Hilsboro. Sec., Gene Johnson, Court House, Fargo.

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

Ohio

Section on Public Health Nursing of State Nurses' Association—Chairman, Sue Z. McCracken, 1201 Cranford Ave., Lakewood. Vice-Chairman, Elizabeth Holt, Dayton. Sec., Bess Augsberger, Lima.

State Nurses' Association Paid Executive —Mrs. Elizabeth P. August, Executive Secretary, 83 E. Gay St., Columbus.

American Red Cross Nursing Field Representative — Julia Groscop, American Red Cross, Washington, D. C.

Oklahoma

State Organization for Public Health Nursing—Pres., Pearl Wilson, State Capitol Bldg., Oklahoma City; Sec., Edna Lewis, 410 So. Cincinnati, Tulsa. Treas., Edna Ashenhurst, Room 211, City Hall, Oklahoma City. Chairman Membership Committee, Mrs. Charlotte Oderkirk, Tulsa.

State Department of Health, Children's Bureau — Edith Hodgson, Supervising Nurse, Room 526, State Capitol Bldg., Oklahoma City.

American Red Cross Nursing Field Representative — Ella Gimmestad, 1709 Washington Ave., St. Louis, Mo.

Oregon

State Organization for Public Health Nursing—Pres., Mrs. Minnette C. Twist, State Board of Health, Portland. Sec., Ruth M. Boedefeld, 303 Fitzpatrick Bldg., Portland. Treas., Jennie Niemela, Court House, Portland. Chairman Membership Committee, Gwendolyn Johnston, 546 East 16th St., N. Portland.

State Board of Health—Bureau of Public Health Nursing, Mrs. Minnette C. Twist, Temporary State Advisory Nurse, Portland.

State Tuberculosis Association Field Nurses—Margaret Gillis, Edna Flanagan, L. Grace Holmes, 310 Fitzpatrick Block, Portland.

State Nurses' Association Paid Executive —Jane Gavin, 404 Mayer Bldg., Portland.

American Red Cross Nursing Field Representative — Gladyce Badger, Civic Auditorium, Larkin and Grove Sts., San Fransisco, Cal.

Pennsylvania

State Organization for Public Health Nursing—Pres., Mrs. Anna Barlow, 429 Walnut St., Reading. Sec., Harriet F. Young, Kirby Health Center, Wilkes-Barre. Treas., Elizabeth Scarborough, 1340 Lombard St., Philadelphia.

State Department of Health—Bureau of nursing—*Temporary vacancy.*

State Department of Public Instruction—Supervisor of School Nursing, Mrs. Lois L. Owen, Commonwealth of Pennsylvania, Harrisburg.

State Tuberculosis Association Field Nurse—Lilah L. Curry, Pennsylvania Tuberculosis Society, 311 S. Juniper St., Philadelphia.

State Nurses' Association Paid Executive —Esther Entriken, Executive Secretary, 400 N. Third St., Harrisburg.

American Red Cross Nursing Field Representatives—Cecilia P. Houston (east) and Marie Peterson (west), American Red Cross, Washington, D. C.

Rhode Island

State Organization for Public Health Nursing—Pres., Nellie R. Dillon, 118 N. Main St., Providence. Sec., Cecilia E. Walsh, 136 Whitford Ave., Providence. Treas., Alice E. Cox, 118 N. Main St. Chairman Membership Committee, Bertha Jutras, 118 No. Main St., Providence.

American Red Cross Nursing Field Representative—Helen Bean, American Red Cross, Washington, D. C.

South Carolina

Committee of Public Health Nursing of State Nurses' Association — Chairman, Nellie C. Cunningham, 1640 Green St., Columbia.

State Board of Health—Bureau of Child Hygiene and Public Health Nursing, Nellie C. Cunningham, Director, State Office Bldg., Columbia.

State Tuberculosis Association Field Nurses—Jennie McMaster, Julia Spratt, Theodosia Flud, 1218 Senate St., Columbia.

American Red Cross Nursing Field Representative—Mary DeLaskey, American Red Cross, Washington, D. C.

South Dakota

Section on Public Health Nursing of State Nurses' Association — Chairman, Anna C. Dailey, Sioux Falls. Sec., Minerva Olsboe, Madison.

State Board of Health—Division of Child Hygiene, Florence E. Walker, Director of Public Health Nursing and Child Hygiene, Waubay.

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

Tennessee

Section on Public Health Nursing of State Nurses' Association—Chairman, Mary J. Dunn, School of Nursing, Vanderbilt University, Nashville. Sec., Mary E. Greene, Metropolitan Life Insurance Co., Knoxville.

State Department of Health—Malvinia G. Nisbet, State Supervisor of Nurses, War Memorial Bldg., Nashville.

American Red Cross Nursing Field Representative — Margaret Dizney, American Red Cross, Washington, D. C.

Texas

State Organization for Public Health Nursing — Pres., Katherine Hagquist, State Board of Health, Austin. Sec.-Treas., Mrs. Frances Gayle, 102 Dwyer Ave., City Health Dept., San Antonio. Chairman Membership Committee, Caroline Atkinson, 608 Bagby St., Houston.

State Board of Health—Bureau of Maternity and Child Hygiene, Katherine Hagquist, State Supervisor of Nurses, Austin.

State Tuberculosis Association Field Nurse—Jean M. Campbell, Texas Public Health Association, 616 Littlefield Bldg., Austin.

State Nurses' Association Paid Executive —A. Louise Dietrich, 1001 E. Nevada St., El Paso.

American Red Cross Nursing Field Representative—Mrs. Myra Cloudman, 1709 Washington Ave., St. Louis.

Utah

State Organization for Public Health Nursing — Pres., Mrs. Evalina Reed, Box 138, Provo. Sec., Alice Hubbard, 228 H St., Salt Lake City. Treas., Mrs. Afton M. Werick, 1213 Fourth Ave., Salt Lake City. Chairman Membership Committee, Evelyn C. Horton, Metropolitan Life Insurance Company, Newhouse Bldg., Salt Lake City.

State Tuberculosis Association — Mrs. Bertha Chase Pederson, Jensen Apts., Salt Lake City.

Vermont

Section on Public Health Nursing of State Nurses' Association—Chairman, Gladys M. Capron, 109 No. Main St., Rutland. Vice-Chairman, Mary Devlin, 4 Spellman Ter., Rutland. Sec., Mrs. Katherine Loomis, Bennington.

State Board of Health—Nellie M. Jones, Maternity and Infancy Division of State Department of Public Health, Brandon.

American Red Cross Nursing Field Representative—Helen W. Gould, American Red Cross, Washington, D. C.

Virginia

Section on Public Health Nursing of State Nurses' Association—Chairman, Hester Lillian Bayley, State Office Bldg., Richmond. Sec., Mrs. Clarissa Spindle, 223 So. Cherry St., Richmond.

State Board of Health—Irma Fortune, Acting Director of Public Health Nursing, Richmond.

American Red Cross Nursing Field Representative — Alice Dugger, American Red Cross, Washington, D. C.

Washington

State Organization for Public Health Nursing — Pres., Frances Norquist,

Medical Dept., Frederick & Nelson, Seattle. Sec.. Mrs. Edna Reynolds, 3811 11th Ave. N. E., Seattle. Treas., Anna Carlson, Court House, Mt. Vernon. Chairman Membership Committee, Grace Coffman, Salvation Army Bldg., Tacoma.

State Department of Health—Division of Public Health Nursing and Child Hygiene, Mrs. Mary Louise Allen, Chief, 1504 Alaska Bldg., Seattle.

State Nurses' Association Paid Executive —Cora E. Gillespie, Executive Secretary, 327 Cobb Bldg., Seattle.

American Red Cross Nursing Field Representative — Gladyce Badger, Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.

West Virginia

Section on Public Health Nursing of State Nurses' Association—Chairman, Lila G. Miller, City-Co. Health Unit, Wheeling, W. Va. Vice-Chairman, Rebecca Barnard, American Red Cross, Fairmont. Sec., Alice Marsh, Berkley Springs.

State Department of Health, Division of Child Hygiene, Field Advisory Nurse—*Temporary Vacancy.*

State Tuberculosis Association Field Nurse—Mary V. Gill, West Virginia Tuberculosis and Health Association, 910 Quarrier St., Charleston.

American Red Cross Nursing Field Representative — Julia Groscop, American Red Cross, Washington, D. C.

Wisconsin

Section on Public Health Nursing of State Nurses' Association—Chairman, Clara B. Rue, Visiting Nurse Association, 787 Van Buren St., Milwaukee. Vice-Chairman, Marie Klein, Court House, Appleton. Sec., Rose Jahimiak, City Health Dept., La Crosse.

State Board of Health—Bureau of Public Health Nursing, Cornelia Van Kooy, Director of Public Health Nursing, Madison.

State Tuberculosis Association Field Nurses — Doris Kerwin, Ada Garvey, Irene Niland, Wisconsin Anti-Tuberculosis Association, 1018 N. Jefferson St., Milwaukee.

American Red Cross Nursing Field Representative—Rebecca Pond, 1709 Washington Ave., St. Louis, Mo.

Wyoming

Public Health Nurses' Association (Not branch of N.O.P.H.N.)—Pres., Mrs. Mayme LeBlanc, 22d and Central Ave., Cheyenne. Vice-Pres., Mrs. Edith Craven, Buffalo. Sec.-Treas., Mrs. Frieda Bailey, 629 E. 11th St., Casper.

State Board of Health—Georgia Zipfel, State Nurse, Capitol, Cheyenne.

Wyoming Tuberculosis Association, 534 Boyd Bldg., Cheyenne. Field Nurses—Mrs. Bess McAvoy, Mrs. Hassie P. Shepard, Box 637, Cheyenne.

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

TERRITORIAL POSSESSIONS

Hawaii

Territorial Board of Health — Mabel L. Smyth, Director of Maternal and Infant Hygiene Division, and Supervising Nurse, Honolulu.

Insular Tuberculosis Association—Stella S. Mathews, Director of Tuberculosis Nurses, Palama Settlement, 1361 Palama St., Honolulu.

Philippine Islands

Philippine Health Service—Public Health Nursing Division, Genera S. Manongdo, Chief Nurse, Manila.

American Red Cross Nursing Field Representative — Pansy Besom, American Red Cross, Manila.

Virgin Islands

American Red Cross Nursing Representative—Mrs. Nancy Hare, St. Croix.

Metropolitan Life Insurance Company Nursing Supervisors—Mrs. Helen C. La Malle, Supt. of Nursing, 1 Madison Ave., New York, N. Y.

Alice Bagley, Asst. Supt. of Nursing, 600 Stockton St., San Francisco, Cal.

Margaret E. Kearney, Asst. Supt. of Nursing, 1 Madison Ave., New York, N. Y.

Alice Ahern, Asst. Supt. of Nursing, 180 Wellington St., Ottawa, Ont., Canada.

Maude E. Steeves, Asst. Supt. of Nursing, 1 Madison Ave., New York, N. Y.

Territorial Supervisors and Territory

Carolyn M. Hidden, 1 Madison Ave., New York, N. Y.: Greater N. Y., Long Island, Westchester County.

L. Carey Jones, 833 Hurt Bldg., Edgewood Ave. and Exchange Place, Atlanta, Ga.: No. Carolina, So. Carolina, George, Florida, Alabama. Mississippi, Louisiana, Virginia.

Isabelle Carruthers, 1319 Ambassador Bldg., St. Louis, Mo.: Missouri, Kansas, Oklahoma, Arkansas, Tennessee.

Mary Harrigan, 1307 Griswold Bldg., Detroit, Mich.: Michigan, Wisconsin, Minnesota, Nebraska, Iowa.

Laura M. Draper, 1107 Public Ledger Bldg., Philadelphia, Pa.: Pennsylvania.

Monica Moore, 1022 Essex Bldg., Newark, N. J.: New Jersey, Delaware, Maryland, District of Columbia.

Sara O'Meara, 1104 Home Savings Bank Bldg., 11 No. Pearl St., Albany, N. Y.: New York State (except Westchester County, Maine, New Hampshire, Vermont.

Ellen M. Atchison, 1007 Waterman Bldg., 44 School St., Boston, Mass.: Massachusetts, Connecticut, Rhode Island.

Ruth King, Room 1123, Chamber of Commerce Bldg., Cincinnati, Ohio: Ohio, Kentucky, West Virginia.

Irene McCullough, Room 601 Lake Michigan Bldg., 180 No. Michigan Ave., Chicago, Ill.: Illinois, Indiana.

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Anna Barr, 210 Baronne St., New Orleans. La.

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Emily Fitzpatrick, Room 6, 39 St. John St., Quebec, Que.

Edna Lynch, 4503 St. Denis St., Montreal, Que.

Josephine Gauthier, 4503 St. Denis St., Montreal, Que.

Irma Van Bockstaele, 354 St. Catherine St., E. Montreal, Que.

Herminie Dupuis, 4360 St. Denis St., Montreal, Que.

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Assistant Director, Agnes V. Murphy, Boston, Mass.

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